

# **A Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire**



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## Section 1: Introduction

The Wisconsin Medicaid prenatal care coordination (PNCC) benefit was implemented on January 1, 1993. The benefit is based on the 11 successful pilot projects funded and evaluated by the Wisconsin Title V Maternal and Child Health program, in the Division of Health (DOH). The DOH administrator appointed a statewide advisory committee to collaborate with the Bureau of Health Care Financing and the Bureau of Public Health on the development of the Medicaid benefit.

In addition to the Medicaid benefit, the DOH provides Title V funding to many local health departments to provide PNCC services to women who may not be eligible for the Medicaid benefit.

PNCC services help pregnant women and, when appropriate, their families gain access to and coordinate a full array of services, including medical, social, educational, vocational, and other services.

PNCC has several goals, all of which center around improving birth outcomes. The primary goals are to ensure that at-risk women:

- Are identified as early as possible in their pregnancy.
- Receive individual psychosocial support.
- Receive early and continuous prenatal care services.
- Are referred to available community services, as appropriate.

The Division of Health (Bureau of Public Health and Bureau of Health Care Financing) developed this Guidance Manual to help prenatal care coordinators (also referred to as case managers) with this very important job. The Guidance Manual includes helpful hints for administering the initial risk assessment (the Pregnancy Questionnaire). It also provides other information to assist care coordinators in planning an appropriate course of action for the expectant mother.

The Pregnancy Questionnaire is used to determine whether a woman is at high risk for a poor birth outcome. A score of 40 points or more qualifies a woman for Medicaid PNCC benefits. For more information on

eligibility, covered services, and limitations of PNCC services, refer to Part Z, the prenatal care coordination services provider handbook. Refer to Attachment 1 of this manual for a copy of the Pregnancy Questionnaire.

In addition to basic information and guidelines for care coordination, this manual also includes helpful attachments. The attachments are designed for quick reference of material that you will need as you work with the expectant mother. They include the following:

- Estimated Date of Delivery Chart.
- Prenatal Weight Gain Grids.
- Pregnancy Questionnaire.
- State Statutes.
- Table of Medical Conditions.
- For More Information, Contact.

WOMEN WHO  
TEND TO GET LATE  
OR NO PRENATAL  
CARE INCLUDE  
VERY YOUNG  
WOMEN, WOMEN  
ON MEDICAID, AND  
MINORITY WOMEN.

You play a vital role in assuring that a woman enrolled for PNCC services receives the care that is essential for a healthy pregnancy and birth. Your role is to help the woman identify her difficulties and eliminate the barriers to prenatal care. In order to help the process, establishing a trusting relationship with the expectant mother is necessary. The sensitive nature of some of the questions in the risk assessment requires you to make the expectant mother feel comfortable enough so she can answer the questions honestly and completely. Since the responses to the questionnaire will guide a plan of care, honest answers are important. Remember that, in general, the information the woman shares with you is confidential; however, the Wisconsin Department of Health and Family Services (DHFS) does have access to the information for evaluation and audit purposes.

The PNCC Guidance Manual will assist you in obtaining information that is crucial for a successful partnership between you and the expectant mom. Research shows that proper risk assessment leads to healthier birth outcomes.





## Section 2: Administering the Pregnancy Questionnaire

THE PURPOSE OF SECTION 2 IS TO HELP YOU ADMINISTER THE PREGNANCY QUESTIONNAIRE.

AS MUCH AS POSSIBLE, PLEASE ASK THE QUESTIONS EXACTLY AS THEY ARE STATED ON THE QUESTIONNAIRE. THIS IS ESPECIALLY IMPORTANT WHEN YOU ASK THE ALCOHOL-RELATED QUESTIONS (D.3 THROUGH D.9). IF THE WOMAN APPEARS NOT TO UNDERSTAND WHAT YOU ARE ASKING, YOU MAY REPHRASE THE QUESTION (EXCEPT FOR QUESTIONS D.3 THROUGH D.9). HOWEVER, PLEASE BE VERY CAREFUL NOT TO CHANGE THE MEANING OF THE QUESTIONS!

YOU MUST COMPLETE AND SCORE THE ENTIRE QUESTIONNAIRE UNLESS THE WOMAN REFUSES TO ANSWER A PARTICULAR QUESTION(S). PLEASE REFER TO ATTACHMENT I OF THIS MANUAL FOR A COPY OF THE PREGNANCY QUESTIONNAIRE.

### A General Information

#### PURPOSE OF THIS SECTION:

TO IDENTIFY SOCIO-DEMOGRAPHIC RISK FACTORS.

1. **Name and address.**  
Record the woman's name and address.
- 2&3.\* **Date of birth and age.**  
Verify consistency of answers.
4. **Medicaid Identification Number.**  
Record the woman's Medicaid number.
- 5.\* **No phone or phone is often disconnected.**  
Check "No phone" if she only has a work number.
6. **How can we contact you?**  
Check all that apply.
- 7.\* **Are you single (never married, separated, divorced, widowed) or married?**  
If the woman indicates that her marriage is not stable, check single.
8. **Your race/ethnic origin.**  
Check the appropriate box.
9. **Do you speak English?**  
Check the appropriate box.
- 10.\* **Do you read English?**  
Check the appropriate box.
11. **Are you in the WIC program?**  
Check the appropriate box.
12. **What are your sources of income?**  
Check only those that are consistent sources.
13. **Are you employed?**  
If she is both a student and employed, check both.

#### *Please note:*

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*

**14.\* What was the last grade you finished? If in school now, do you attend regularly?**

Record the last grade completed and check the appropriate box.

**15.\* Have you in the past, or are you currently receiving special education services or exceptional education services?**

Check “yes” no matter what type of special or exceptional education service(s) she received or is receiving.

**16.\* Where do you live?**

Check the appropriate box.

**17.\* How many times have you moved in the last year?**

Include temporary relocations that were not visits. For example, include a three-week stay with a family member/friend while looking for a place to live. Do not include a two-month stay with an ill family member or friend.

**18. Name of parent, guardian, or person to call in an emergency.**

Record the information the woman provides.

# B About this Pregnancy

## PURPOSE OF THIS SECTION:

PROVIDE INFORMATION ABOUT ADEQUACY OF CARE AND EARLY SIGNS OF COMPLICATIONS FOR THE WOMAN'S CURRENT PREGNANCY.

1. **How “far along” are you now?**  
Record the information provided.
- 2.\* **How far along were you when you started seeing a health care provider for prenatal care?**  
Record the information provided.
- 3.\* **Have you seen your health care provider at least monthly for this pregnancy?**  
Check the appropriate box.
- 4.\* **Are you pregnant with more than one baby?**  
Check “yes” only if a health care provider gave her confirmation.
- 5.\* **Have you had any signs of early labor?**  
Check the appropriate box.
- 6.\* **Have you gone to the emergency room or hospital for this pregnancy?**  
Check “yes” only if the visit was pregnancy-related.
7. **Would you like more information or help with any of these things?**  
Check all that apply. Write down any additional information.

### ***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*



## PURPOSE OF THIS SECTION:

TO OBTAIN INFORMATION ABOUT THE WOMAN'S MEDICAL AND CHILDBEARING HISTORY, AND TO IDENTIFY PAST OR CURRENT MEDICAL CONDITIONS THAT MAY INFLUENCE THE OUTCOME OF HER CURRENT PREGNANCY.

**1.\* Do you have, or have you ever had, any of these conditions?**

For the medical conditions, check only if she indicates that a health care provider confirmed the condition.

**2.\* How many times have you been pregnant before this pregnancy?**

Record the number of confirmed pregnancies.

**3.\* Have you had any miscarriages?**

Record the number of miscarriages.

**4.\* Have you had any abortions?**

Record the number of induced abortions.

**5. Have you had twins or multiple births?**

Check the appropriate box.

**6.\* Have you ever had a C-Section?**

Check the appropriate box.

**7.\* Did you have a baby within the last year?**

Check the appropriate box.

**8.\* Were any of your babies born more than 3 weeks early?**

Check the appropriate box.

**9.\* Did a doctor ever say you had premature labor that required bed rest, medication, and/or hospitalization?**

Check the appropriate box.

**10.\* Have you had a stillborn baby (born dead after 20 weeks), or one that died soon after birth?**

Check the appropriate box.

**11.\* Did any of your babies weigh less than 5½ pounds at birth?**

Check the appropriate box.

**12.\* Did any weigh more than 10 pounds at birth?**

Check the appropriate box.

**13.\* Did any stay more than one day in a special care nursery?**

Check the appropriate box.

**14.\* When did you start prenatal care during your last pregnancy?**

Check the appropriate box.

***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*



# D Alcohol, Medicines, & Other Drugs

## PURPOSE OF THIS SECTION:

TO OBTAIN INFORMATION ABOUT THE  
WOMAN'S USE OF TOBACCO, ALCOHOL,  
ILLICIT DRUGS, OR MEDICATIONS.

1. **During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?**  
Check the appropriate box.
- 2.\* **On average, how many cigarettes do you smoke a day now?**  
Check the appropriate box.

*Do not rephrase Questions D.3 through D.9.*

- 3.\* **How many drinks does it take to make you feel high?**  
“High” is subjective. Accept her interpretation.
- 4.\* **How much can you hold?**  
“Hold” is subjective. Accept her interpretation.
- 5.\* **Have people annoyed you by criticizing your drinking?**  
Check the appropriate box.
- 6.\* **Have you ever felt you ought to cut down on your drinking?**  
Check the appropriate box.
- 7.\* **Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?**  
Check the appropriate box.
- 8.\* **Since you became pregnant, about how many days in a month do you have 3 or more drinks?**  
Record the number of days.

9. **Since you became pregnant, about how many days in a month do you have one or more drinks?**  
Record the number of days.
10. **Have you taken any prescription drugs since you became pregnant?**  
Check the appropriate box.
11. **Have you taken any over-the-counter drugs since you became pregnant?**  
Check the appropriate box.
- 12.\* **Have you ever injected a non-prescribed drug?**  
Check the appropriate box.
13. **Number of different persons with whom you shared intravenous drug needles or syringes, or “works” within the last 10 years...last 12 months.**  
Record the number of persons for each.
- 14.\* **Do you think any of these persons were infected with HIV (the AIDS virus)?**  
Check the appropriate box.
- 15.\* **How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant?**  
Check the appropriate box.
- 16.\* **How often did you use cocaine or crack during the 3 months before you found out that you were pregnant?**  
Check the appropriate box.
- 17.\* **How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc., during the 3 months before you found out that you were pregnant?**  
Check the appropriate box.

### ***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*



# E Nutrition

## PURPOSE OF THIS SECTION:

TO OBTAIN INFORMATION ABOUT THE WOMAN'S CURRENT EATING BEHAVIORS AND NUTRITIONAL STATUS.

- 1.\* **How much did you weigh before you became pregnant this time?**  
**How tall are you?**  
Record the woman's prepregnancy weight and height. (To assess and categorize the woman's prepregnancy weight, use the Body Mass Index Grid in Attachment 2.)
- 2.\* **How much do you weigh now?**  
Record the woman's weight.
3. **Have you ever vomited to control your weight or vomited to feel better after eating too much?**  
Check the appropriate box.
- 4.\* **Do you vomit often now?**  
"Often" is subjective. Accept her response.
5. **Are you having any of the following symptoms now:**  
**Nausea, Heartburn, Constipation**  
Check the appropriate box.
6. **When you were not pregnant, did you feel that your weight and your body shape were: about right, overweight/too large, underweight/too small?**  
Check the appropriate alternative.
7. **Are you on a special diet now?**  
Check the appropriate box.
- 8.\* **Do you eat corn starch out of the box, laundry starch, paint chips, lots of ice, clay, dirt or other things that are not food?**  
Check "yes" if she indicates that she has eaten nonfood items just before or during the pregnancy.
- 9.\* **During the past month did you miss any meals or not eat when you were hungry because there wasn't enough food or money to buy food?**  
Check the appropriate box.
- 10.\* **Do you have a working stove and refrigerator?**  
Check "no" if one or the other is not working.

### ***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*



# F Relationships

## PURPOSE OF THIS SECTION:

TO HELP YOU LEARN ABOUT THE WOMAN'S SOCIAL SUPPORT NETWORK (HUSBAND, PARTNER, PARENTS, OTHER FAMILY, FRIENDS, AND NEIGHBORS), HER FEELINGS OF SELF-WORTH, COMPETENCY, AND PERSONAL SAFETY.

- 1.\* **How do you feel now about being pregnant?**  
Check the appropriate box.
- 2.\* **How does your husband or partner feel now about you being pregnant?**  
Check the appropriate box.
- 3.\* **How often did you feel depressed during the last week?**  
Check the appropriate box.
4. **How many living children do you have?**  
Record the number of children.
5. **How many of them are living in your household now?**  
Record the number of children living in the household.
- 6.\* **Within the past 12 months, have any of your children been taken from you?**  
Check the appropriate box.
- 7.\* **Have you ever had sexual contact with any of the following: HIV-infected partner, IV drug user, bisexual partner, hemophiliac?**  
Check the appropriate box.
- 8.\* **Have you given or received money or drugs for sex?**  
Check the appropriate box.
- 9.\* **Does your partner have a problem with alcohol or other drugs?**  
"Problem" is subjective. Accept her response.
- 10.\* **Does anyone else in your family have a problem with alcohol or other drugs? What relation is this person to you?**  
Check the appropriate box. Include persons who are not "blood" relatives but who were raised as relatives.
- 11.\* **Have you ever been emotionally, verbally, or physically abused by your partner, or someone close to you?**  
Check the appropriate box.
12. **Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?**  
Check the appropriate box.
- 13.\* **Since you have been pregnant, were you hit, slapped, or kicked, or otherwise physically hurt by someone?**  
Check the appropriate box.  
*Note:* Individuals whose employment brings them into contact with children under the age of 18 are required by law (Wisconsin Child Abuse Act) to report any suspected abuse or neglect or a belief that abuse or neglect will occur to their county child protection/social service agency.
- 14.\* **Has anyone forced you to have sexual contact?**  
Check the appropriate box.
15. **Have other family members been sexually assaulted or abused?**  
Check the appropriate box.
- 16.\* **Are you afraid of your partner or anyone else?**  
Check the appropriate box.
17. **Is there a gun in your home?**  
Check the appropriate box.
- 18.\* **Is there someone you can talk to when you have a problem?**  
Check "yes" if the person is a consistent source. For example, their hairdresser or the mail carrier would not count.

**19.\* How many people can you really count on when you need help?**

Check the appropriate box.

**20. What do you do to deal with your problems?**

Record the response.

This open-ended question provides the woman with an opportunity to share her strengths.

Understanding her strengths will help you develop a realistic care plan with her.

***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*

# G Worries

## PURPOSE OF THIS SECTION:

TO ALLOW THE WOMAN TO IDENTIFY AND TALK ABOUT HER WORRIES AND CONCERNS WITH YOU.

### **1.\* Which of these things worry you a lot?**

Check only those items that are significant problems.

### **2.\* How often do you have problems getting transportation?**

This question relates to transportation to carry out activities of daily living, including:

- Grocery shopping.
- Medical and nonmedical appointments.
- Visits to obtain/maintain a support system.

#### *Additional worries.*

Allow the woman to identify any additional concerns. Although answers are not scored, this will allow both of you to understand all the issues she is facing during her pregnancy.

#### ***Please note:***

*All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (\*) are scored on the pregnancy questionnaire. Use this section while you administer the questionnaire. Refer to Section 3 of this guidance manual for background information on the questions.*





## Section 3: Background Information

THE PURPOSE OF SECTION 3 IS TO PROVIDE YOU WITH SOME BACKGROUND ON THE IMPORTANCE OR RELEVANCE OF SELECT QUESTIONS. IT IS ALSO INTENDED TO HELP YOU IN PLANNING AN APPROPRIATE COURSE OF ACTION FOR THE WOMAN. THE INFORMATION IN THIS SECTION IS GENERALLY ORGANIZED AS IT IS ON THE PREGNANCY QUESTIONNAIRE. PLEASE REFER TO ATTACHMENT 1 FOR A COPY OF THE QUESTIONNAIRE.

ATTACHMENT 3 OF THIS MANUAL LISTS TELEPHONE NUMBERS YOU MAY CALL FOR MORE INFORMATION ON SOME OF THE TOPICS DISCUSSED IN THIS SECTION. YOU MAY ALSO CONTACT THE BUREAU OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SECTION, AT (608) 267-0531 FOR MORE INFORMATION ON ANY OF THE TOPICS DISCUSSED.

### A General Information

The Pregnancy Questionnaire is primarily nonmedical. There are medical questions, but they are limited in nature and do not represent a comprehensive physical assessment. The pregnant woman must be under the care of a physician, certified nurse midwife, or nurse practitioner. If she does not have a health care provider, help her find one immediately. If she is enrolled in a Medicaid HMO, contact the HMO's member services.

#### Age of the Woman

It is important that young women understand what their bodies are going through, especially if this is the first pregnancy. Teenage childbearing presents risks to both mother and child due to a variety of factors, including inadequate weight gain, poor nutrition, sexually transmitted diseases, and complications during pregnancy, labor, and delivery. Though being young is a risk factor, social class and quality of prenatal care also determine whether the woman is at high risk for a poor birth outcome. Teenage mothers are less likely to seek early prenatal care and often do not receive any prenatal care services at all.

Women who are over 40 face some additional risk for genetic/chromosomal defects and for effects of chronic disease.

#### Marital Status

Single women are generally considered to be at higher risk for poor birth outcomes. The Wisconsin Department of Health and Family Services (DHFS) confirmed the finding that those mothers who are unmarried have a consistently higher risk of bearing low birth weight infants than those who are married. Unmarried mothers usually have to rely on themselves more and may not have the emotional support they need.

#### Race/Ethnic Origin

All services delivered to the pregnant woman should be culturally competent. Cultural competence refers to a program's ability to honor and respect beliefs, interpersonal styles, attitudes, and behaviors of the woman and other family members. It is also important that information is presented to the woman in the language that she can clearly understand.

#### WIC Program

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

PREGNANT WOMEN AND ADOLESCENTS WITH NUTRITION-RELATED RISKS AND INCOMES BELOW 185 PERCENT OF POVERTY ARE ELIGIBLE FOR WIC.

provides nutrition education, special supplemental foods, and encourages use of other needed health and social services. Pregnant women and adolescents with nutrition-related risks and incomes below a certain poverty level are eligible for WIC. In general, most Medicaid eligible pregnant women are also eligible to receive WIC services. If the woman is *not* enrolled in WIC, explain the benefits of WIC and help her contact the local project. Encourage women who are enrolled in WIC to pick up food drafts and attend nutrition counseling sessions regularly.

WIC cannot provide comprehensive nutrition assessments and care. The WIC Program provides a *minimum* nutrition assessment to determine WIC eligibility, basic nutrition counseling, and at least one mid-certification contact. Please refer to Part Z, the prenatal care coordination handbook, for information on nutrition education services covered by PNCC.

## Income/Employment

This information provides additional insight into her financial security and/or independence. If there is a possibility that the woman is exposed to occupational health hazards, encourage her to talk to her health care provider about it. Individual occupational hazards need to be identified and analyzed to determine appropriate

intervention strategies. If the woman is employed, ask her the following questions:

- *Does your job require heavy lifting or moving?*
- *Does your job require strenuous physical activity?*
- *Are you exposed to chemicals or other substances (i.e. lead, dusts, fumes, radiation) on the job?*

Refer to Attachment 3 for more contact information.

## Education

Education is an important factor in determining birth outcome. Screening for education level identifies women with a wide variety of risk factors. If the woman has less than 12 years of education, she is less likely to obtain early prenatal care, and she is more likely to have a poor birth outcome. If she has not graduated from high school, encourage her and help her make the necessary phone calls and contacts to begin her General Equivalency Diploma (GED) schooling. This will reap lifelong benefits for her and her family.

It is also important to identify women who have special learning needs who may need lower-level reading materials and information presented to them in a way they can understand. A woman might say she

## WIC Definition for homeless:

A WOMAN WHO LACKS A FIXED OR REGULAR NIGHTTIME RESIDENCE OR WHOSE PRIMARY NIGHTTIME RESIDENCE INCLUDES ONE OF THE FOLLOWING:

- A SUPERVISED PUBLICLY OR PRIVATELY OPERATED SHELTER (INCLUDES A WELFARE HOTEL, A CONGREGATE SHELTER, OR A SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE) DESIGNATED TO PROVIDE TEMPORARY LIVING ACCOMMODATIONS.
- AN INSTITUTION THAT PROVIDES A TEMPORARY RESIDENCE FOR INDIVIDUALS INTENDED TO BE INSTITUTIONALIZED.
- A TEMPORARY ACCOMMODATION IN THE RESIDENCE OF ANOTHER INDIVIDUAL.
- A PUBLIC OR PRIVATE PLACE NOT DESIGNED FOR, OR ORDINARILY USED AS, REGULAR SLEEPING ACCOMMODATION FOR HUMAN BEINGS.

understands your directions but, in fact, does not understand what you mean. A clear understanding of her limitations will help you differentiate between noncomprehension and noncompliance.

## **Place of Residence**

Information on where a woman lives will provide you with additional insights on issues regarding her economic stability, social support system, and personal safety. For example, a woman who lives in a shelter may have been threatened or physically abused at home. A woman who is homeless is at high risk for a poor pregnancy outcome due to a combination of psychosocial and medical factors, such as severe poverty, lack of a support system, and increased exposure to disease.

The WIC definition of homeless includes women who are temporarily living with friends or relatives. Living with family members or friends is still recognized as stressful even if the living arrangement is permanent and stable.

If the woman moves frequently, you may want to obtain another contact name (friend or relative) to make it easier to contact her. The presence of a social support network is important for the woman so she has a healthy baby. If the woman says a “neighbor” is a person to contact in case of an emergency, it may suggest that the woman does not have a strong support system.



# B About this Pregnancy

Early prenatal care is one of the most important factors in improving birth outcomes. This section of the questionnaire provides information about the adequacy of prenatal care a woman is currently receiving and early signs of pregnancy complications. By finding out what kind of care the woman is receiving and identifying any barriers that might complicate the receipt of prenatal care, you can plan her care accordingly.

Your job is to make sure that the woman has access to early and continuous health care, if she hasn't already done so, and to address any concerns or questions she may have about prenatal care, labor, delivery, and infant care.

Early and continuous quality prenatal care remains the most effective, cost-saving way to increase birth weight and improve infant health. Prenatal care is especially important for those women at highest risk because of their social conditions and health status.

## Prenatal Medical Care

For a healthy birth outcome, prenatal care is essential. Women who have inadequate prenatal care are three times more likely to have a low birth weight infant than are women who have *early* and *continuous* prenatal care.

A woman who is in her second trimester and has not seen a doctor, certified nurse midwife, or nurse practitioner is at risk for a poor birth outcome. The woman's risk increases as the pregnancy progresses without medical attention. A pregnant woman who has not received prenatal care and is in her third trimester is at *high risk* for a negative birth outcome. Also,

### Barriers to Prenatal Care Include:

- FINANCIAL PROBLEMS.
- TRANSPORTATION PROBLEMS.
- TIME CONFLICTS.
- AMBIVALENT FEELINGS ABOUT PREGNANCY.
- BELIEF THAT PRENATAL CARE IS NOT IMPORTANT.
- LACK OF KNOWLEDGE ABOUT PRENATAL CARE.

women who abuse alcohol or other drugs are the least likely group to seek prenatal care.

Make direct contact with a health care provider and schedule an appointment before the woman leaves your agency. If necessary, discuss with the woman how she plans to get to her prenatal visit. If the woman does not know her due date, you can help her estimate it. Refer to Attachment 4 for an Estimated Date of Delivery chart.

Once you know if a woman has received prenatal care and, if so, how many times she has seen her health care provider, you can determine if the level of care is adequate. One way to determine the adequacy of prenatal care is the Kessner Index. The index is based on which trimester the care began and the number of visits. The Kessner Index uses the following classifications:

- *Adequate*: Initiation in the first trimester with nine or more visits.
- *Intermediate*: Initiation in the first trimester with five to eight visits, or initiation in the second trimester with five or more visits.
- *Inadequate*: Initiation in the second trimester with one to four visits, or initiation in the third trimester with one or more visits.

Although the Kessner Index can quantify some aspects of prenatal care, it cannot measure the *quality* of prenatal care. Quality prenatal care must go beyond increasing the number of prenatal medical visits. The actual prenatal care content is also critical.

## Multiple Births

Multiple births and premature labor are risk factors which can negatively affect the birth outcome. There are several medical complications associated with multiple gestation including the following:

- Low birth weight.
- Maternal anemia.
- Premature birth.
- Placental or umbilical cord problems.
- Pregnancy-induced hypertension.
- Baby's abnormal position in the uterus.

The serious nature of these complications further illustrates the importance of early and comprehensive prenatal care.

## Signs of Early Labor

If a woman indicates that she has experienced symptoms of premature labor, the risk for premature delivery greatly increases. A woman who has experienced any of these symptoms should see a medical provider immediately.

Signs of premature labor include the following:

- Pelvic or lower abdominal pressure.
- Constant, low backache.
- Change in vaginal discharge.
- Mild abdominal cramps.
- Regular contractions or uterine tightening.
- Ruptured membranes.

## Basic Information and Health Education During Pregnancy

One of the most important roles as a care coordinator is as an educator. Refer to Part Z, the prenatal care coordination services handbook, for the guidelines on providing health education.

Provide health education to women who need more time and specialized education to make changes in high-risk behaviors and lifestyles. Women who need health education often require innovative and individualized educational approaches to effectively meet their needs. The educational interventions must target high-risk medical conditions and high-risk health behaviors that can be alleviated or improved through education. Health education must be based on the woman's risk assessment and care plan.

The intent of health education is to promote behavior change in the woman's daily life that will support a healthy pregnancy and result in an improved birth outcome. Behavior and lifestyle changes resulting from health education may have long term effects on improving the health of the mother, baby, and subsequent pregnancies.

### *Please note:*

Significant medical or psychosocial risks must be referred for appropriate treatment.

# C Medical History

The more you know about the woman's medical condition, the better. This information does *not* take the place of a medical prenatal exam. A woman must be under the care of a health professional. Communicate with the woman's health care provider about pertinent medical conditions and develop a plan of care that integrates management of her medical and prenatal care needs.

Most likely a woman who had difficulty obtaining prenatal care during previous pregnancies will experience similar barriers during this pregnancy. Overall, the most important risk factors for pre-term labor include the following:

- History of previous premature birth.
- Multiple gestation.
- History of late (second trimester) miscarriage.
- Cigarette or cocaine use.

## Medical Conditions

There are many medical conditions that can negatively affect birth outcome. Refer to Attachment 5 for more information about each condition listed on the Pregnancy Questionnaire.

## Previous Pregnancies

Obtaining information about previous pregnancies will help you determine the amount and type of information and education that the pregnant woman may need. If this is her first pregnancy, you will need to spend more time sharing the basic information regarding normal physical and emotional changes, fetal growth and development, positive health behaviors, warning signs of premature labor and delivery, and infant care.

Women who have been pregnant before will need different information. Women with five or more previous pregnancies are considered at high risk for a poor birth outcome. The reasons for this are varied but include an increase in medical problems and additional psychosocial stressors.

## Miscarriages

If two or three miscarriages occur in a row, there may be an underlying medical problem. Encourage the woman to share this information with her health care provider. Help the woman understand the signs and symptoms of a miscarriage, the importance of prenatal care, and, if necessary, refer her to grief counseling regarding the loss of the pregnancy.

## Abortions

The relationship of induced abortion to subsequent pregnancies is not fully known. However, multiple abortions increase the risk for an incompetent cervix, which may result in a miscarriage or preterm delivery.

## Twins or Multiple Births

Many twin infants have low birth weights, even at full term. There is an increased risk of medical complications with multiple fetuses, such as preeclampsia, anemia, preterm labor, low birth weight, and Cesarean delivery.

## Cesarean-Sections

If a woman had a previous Cesarean-section, find out why it was necessary. In the past, the type of incision used during a C-section operation required that all subsequent babies be delivered by C-section. Now, with different surgical techniques and labor management practices, many women can have a vaginal birth after a previous C-section.

Encourage the woman to talk to her health care provider about the type of delivery she can anticipate. Provide the support and information she needs as the time of delivery comes closer. If a woman needs a C-section and it is planned in advance, help her get her support network in place before she comes home. Refer the woman to a local C-section support group, if available.

### Women at particular risk for miscarriage include those who:

- SMOKE.
- DRINK ALCOHOL.
- USE ILLICIT DRUGS.
- HAVE HIGH BLOOD PRESSURE.
- HAVE DIABETES.
- HAVE AN INCOMPETENT CERVIX.
- HAVE HAD MULTIPLE PREGNANCIES.

## Interval Between Pregnancies

The risk of having a low birth weight baby is higher when the interval between pregnancies is less than six months. A short pregnancy interval places a great demand on the woman's body, particularly if she is nursing the other child. In addition, the closeness of this pregnancy to a past pregnancy may indicate a lack of knowledge or understanding about the reproductive system and family planning.

## Premature Labor

Infant size at birth is a key determinant of child health. An infant may be born small because it was born too early. The average length of pregnancy is 40 weeks. Premature infants are born before 37 weeks gestation. A history of preterm births is one of the best predictors of a subsequent preterm birth.

Interventions to reduce preterm births include the following:

- Identifying women who have had a previous preterm delivery, multiple gestation, incompetent cervix, low prepregnancy weight, or signs of preeclampsia.
- Educating health care providers about their role in identifying and treating women for preterm labor.
- Educating the woman about the risk of preterm labor and early warning signs, especially bleeding.
- Establishing a system so the woman can contact her health care provider immediately.
- Instituting a medication system, including tocolytic medications.
- Requiring bed rest and/or hospitalization during pregnancy.

Help the pregnant woman understand her medical provider's recommendations.

## Fetal Death

A previous fetal or neonatal death increases the risk for the same adverse outcome in subsequent pregnancies. A stillbirth or death of a newborn can be a devastating loss for the parents. They may feel guilty and may blame themselves. A woman who has experienced perinatal loss may have mixed feelings about her current pregnancy. She may feel that the same thing will happen to this baby.

Fetal death, also known as "stillbirth," is a birth that occurs late in the pregnancy, and close to the due date, and shows no signs of life. A fetal death is reported and counted if it occurs at a minimum of 20 weeks gestation or weighs at least 350 grams.

A "neonatal death" is the death of a live-born infant at less than four weeks of age.

## Birth Weight of Other Children

An infant birth weight of less than 5.5 pounds, or 2500 grams, is considered to be low. Very low birth weight babies, weighing 1500 grams or less, are at high risk for neonatal death and other health complications.

Large infants (those having a birth weight over 10 pounds) have a higher incidence of birth injuries. A large baby may be due to heredity but may also be the result of a diabetic or prediabetic mother. If diabetes is suspected, inform the woman of the signs and symptoms. Report any changes to her health care provider.

## Special Care Nursery

You may be able to anticipate potential problems with this pregnancy if you know the history of previous pregnancies. Infants are placed in a special care nursery for many conditions, including:

- Blood group incompatibilities (for example, Rh factor).
- Low birth weight.
- Cardiac or gastrointestinal problems.
- Prematurity.
- Drug exposure.
- Respiratory problems.
- Low Apgar scores.

Encourage the woman to let her health care provider know if she had an infant stay for a day or more in a special care nursery.

## Previous Prenatal Care

Early and continuous prenatal medical care is extremely important. Women who have inadequate prenatal care are three times more likely to have a low birth weight infant than are women who have early and continuous prenatal care.

# D Alcohol, Medicines, & Other Drugs

The use of tobacco, alcohol, illicit drugs, or medications before and during pregnancy can cause serious complications. In addition to risks to the mother's health, there are many negative effects on the unborn child. This section provides information about the risks and outcomes of substance abuse on the expectant mother and the baby.

The questionnaire is designed so that the questions directly related to substance abuse pertain to the expectant mother's behavior in the three months *before* she became pregnant to encourage the woman to answer the questions honestly. No expectant mother wants to be seen as a "bad mother," and by asking questions about the time before the woman became pregnant, she may reveal patterns of abuse that must be addressed to help reduce the risk of a poor birth outcome.

## Tobacco

Smoking is one of the most important and preventable determinants of low birth weight in the United States. Smoking during pregnancy increases the risk of Sudden Infant Death Syndrome (SIDS) about threefold. A baby's exposure to passive smoke by the mother, the father, or other household members increases the risk of SIDS by twofold. Smoking during pregnancy is harmful to the unborn baby in several ways including the following:

- A higher risk for intrauterine growth retardation (IUGR), which is the failure of the fetus to grow at a normal rate during gestation.
- More frequent miscarriages, premature deliveries, and stillbirths.
- Harmful effects on maternal nutrition, including lower availability of calories due to increased metabolism and the depletion of certain nutrients such as iron and vitamin B<sub>12</sub>.
- Risk for premature rupture of the membranes which triggers premature labor.
- A higher risk for a reduction in birth weight ranging from 150 to 250 grams.

In addition to the harmful effects during pregnancy, infants of mothers who smoke are more likely to suffer

from respiratory illnesses and are at an increased risk for SIDS.

Encourage the woman to reduce or stop smoking. When a woman is pregnant, she may be more motivated to quit than at any other time in her life, and the earlier in pregnancy a woman stops smoking, the better her chances for delivering an average-weight baby.

If a woman expresses her desire to quit smoking, direct her to the appropriate resources such as the American Cancer Society which offers a course called "Special Delivery" designed specifically for pregnant women. Refer to Attachment 3 for contact information.

Women who smoke and plan to breast-feed should follow these recommendations:

- Stop or decrease smoking to the *greatest* degree possible.
- Avoid smoking just before nursing.
- Do not smoke in the same room with the infant.

STUDIES SHOW THAT BETWEEN 21 AND 29 PERCENT OF ALL LOW BIRTH WEIGHT BABIES CAN BE ATTRIBUTED TO MATERNAL SMOKING.

Emotional support, health education, and follow-up will give the woman the skills she needs to make healthy decisions.

## Alcohol

Alcohol use during pregnancy can lead to low birth weight, premature birth, fetal and neonatal death, Fetal Alcohol Effects (FAE), or Fetal Alcohol Syndrome (FAS). There are several questions which address a woman's alcohol use. It is important that you encourage the woman to seek treatment if she abuses alcohol in order to improve her health and the health of her unborn child. Refer to Attachment 6 for information about Alcohol and Other Drug Abuse (AODA) treatment for pregnant women.

## T-ACE Assessment

The questions about alcohol use are structured to identify risk-drinking. Risk-drinking is defined by the amount of maternal drinking associated with harm to the fetus. These questions are known as T-ACE questions (**T**olerance, **A**nnoyed, **C**ut down, and **E**ye-opener). It is your job to convey the message that there is no *safe* level of alcohol consumption during pregnancy.

The following list outlines the main objectives of the T-ACE assessment:

- *How many drinks does it take to make you feel high?*  
**T-** This question indicates the woman's tolerance level regarding alcohol.
- *Have people annoyed you by criticizing your drinking?*  
**A-** This question examines how the woman's drinking annoys or impacts others in her life.
- *Have you ever felt you ought to cut down on your drinking?*  
**C-** This question helps the woman examine the role alcohol plays in her life and whether she feels that she needs to cut down her drinking.
- *Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?*  
**E-** This question determines if a woman is physically addicted and needs alcohol as an eye-opener.

A pregnant woman should understand that when she drinks an alcoholic beverage, the concentration of alcohol in her unborn baby's bloodstream is the *same level as her own*. Alcohol consumption at any time during the pregnancy is potentially harmful to the fetus, and timing and duration of exposure can be related to the type of damage likely to occur. The following list includes some of the harmful effects of alcohol consumption during pregnancy:

IF A PREGNANT WOMAN DRINKS ALCOHOL, THE CONCENTRATION OF ALCOHOL IN HER UNBORN BABY'S BLOODSTREAM IS THE SAME LEVEL AS HER OWN.

- *During the first trimester:* Major organs are developing and miscarriage may occur. Alcohol is toxic to the developing embryo and fetus and may cause malformations or abnormalities, including a decrease in the number of brain cells.
- *During the second trimester:* Miscarriages continue to be a risk and premature separation of the placenta is another concern.

- *During the third trimester:* Overall growth, including brain development, may be impaired and result in low birth weight and intrauterine growth retardation which affects weight, length, head, and chest circumference.

Women who use alcohol during pregnancy compromise their nutritional status. Studies have found low intakes of protein, dairy foods, cereal and bread, calcium, certain B vitamins, and vitamin D among women who consume alcohol during pregnancy.

FAS is another risk associated with alcohol consumption during pregnancy. FAS may lead to the following:

- Prenatal and postnatal growth retardation.
- Central nervous system disorders.
- Abnormal craniofacial features.

FAS is the leading preventable cause of mental retardation. Less severely affected infants who may not exhibit all of these characteristics may be categorized as having FAE.

## Medicines

A pregnant woman should be informed that the use of over-the-counter and prescription medicines may be harmful to her unborn child. Often tranquilizers, sleeping pills, cold remedies, and other commonly used drugs are misused because they are taken more frequently than recommended, in larger than prescribed doses, or over a longer time than indicated. Advise a woman who is taking a prescribed medication to consult with her health care provider about treatment during pregnancy.

## Illicit Drugs

Substance abuse during pregnancy increases the risk for miscarriage, bleeding problems and stillbirths. While the long term effects are not clear, the infant is more likely to be premature, have low birth weight, and have some adverse changes in neurological development.

Diseases of addiction to harmful and illegal drugs do not spontaneously halt during pregnancy. It is difficult to estimate use of these substances during pregnancy, but one estimate is that approximately 11 percent of pregnant women use heroin, methadone, amphetamines, PCP, marijuana, inhalants or cocaine. Many women are reluctant to openly discuss their drug use because of fear of criminal prosecution or termination of child custody. If

the woman does show signs of possible substance abuse, it is important that she be referred to a provider who can discuss this in a nonthreatening, therapeutic manner. Treatment for substance abuse during pregnancy is critical and women do have first priority for admission to AODA treatment programs.

If the woman has injected drugs, she is at increased risk for exposure to HIV/AIDS and Hepatitis B. Refer to Part F of this Section for more information about HIV/AIDS. Refer to Attachment 5 of this Guide for more information about Hepatitis B.



# E Nutrition

Adequate nutrition is one of the most important influences on the health of pregnant women and their infants. To help women achieve optimal nutritional status, nutrition services should be available from trained health care professionals.

Every pregnant woman needs to be screened for her dietary practices, knowledge about nutrition, and her understanding of how these factors affect pregnancy outcome for both the mother and the fetus. This screening and basic information sharing should begin with her first visit and continue throughout the pregnancy. Basic nutrition information should include reinforcement of positive nutrition practices. To maximize resources, coordinate the provision of this screening and basic nutrition information with WIC program services.

In coordination with WIC Program services, provide or reinforce basic nutrition information as needed. Please refer to Part Z, the prenatal care coordination handbook, for guidelines on providing nutrition education.

For women with certain conditions and/or diseases, medical nutrition therapy is a vital component of their prenatal care. Please refer to Attachment 5 for additional information on conditions/sicknesses. If the woman has special dietary needs, she should see a therapeutic dietitian or nutrition professional. The nutrition care plan should include the following:

- Diet counseling that accommodates cultural preferences.
- Skill building regarding food purchasing.
- Preparation and meal planning.
- Behavior change interventions.

## Prepregnancy Weight

Prepregnancy weight may be a better indicator of risk for poor outcomes than weight gain during the pregnancy. To determine if a woman is underweight, overweight, or obese, weight and height must be compared and evaluated. The woman and fetus are at higher risk if the woman has a prepregnancy weight of less than 20.0 or greater than 26.0 Body Mass Index (BMI). Refer to

Attachment 2 to estimate the woman's BMI, to determine the relationship of body weight to height, and to assess and categorize her prepregnancy weight.

## Weight During Pregnancy

Weight loss or no weight gain by the second trimester, or weight gain greater than 6.5 pounds per month greatly increases the risks for the woman and her infant. A normal weight gain rate is approximately 1 pound per week in the second and third trimester. Underweight women should gain slightly more and overweight women should gain slightly less. A sudden increase in weight after the twelfth week of pregnancy caused by fluid retention may be related to the onset of preeclampsia. Any weight loss during the second or third trimester is indicative of complications. If you are providing nutrition counseling, weigh the woman each month and plot her weight on the Prenatal Weight Gain Grid at each visit. Refer to Attachment 7 for a sample grid.

If weight gain is consistently falling below or above the recommendations, nutrition care from a dietitian is strongly recommended. Also, participation in the WIC

program needs to be reassessed to ensure consistent participation and appropriate use of WIC foods. Make an immediate referral to her health care provider if you see any serious weight changes.

MAKE IMMEDIATE  
REFERRAL TO HER  
HEALTH CARE  
PROVIDER IF YOU SEE  
ANY SERIOUS WEIGHT  
CHANGES.

## Symptoms During Pregnancy

As a common symptom during pregnancy, it is normal for about 50 percent of pregnant women to experience vomiting during the sixth week to about the sixteenth week of pregnancy. Severe or prolonged vomiting during pregnancy may become life-threatening if it is not controlled. Any vomiting during the third trimester requires immediate referral to her health care provider.

Suggest the following if the expectant mom is having the following symptoms:

### Nausea

- Eat small, frequent meals (every 2 to 3 hours) including a snack of bread or crackers at bedtime and before getting out of bed in the morning.
- Eat easily digested carbohydrates and avoid high-fat foods.

- Drink liquids (clear broth and juice) between meals.
- Avoid cooking odors and pungent smells.

### Heartburn

- Eat several small meals a day.
- Drink a lot of fluids.
- Avoid greasy or highly seasoned foods, coffee, and cigarettes.
- Do not lie down after eating.
- Sleep with head slightly elevated.

### Constipation

- Eat high fiber foods.
- Drink a lot of fluids.
- Chew food thoroughly.
- Exercise daily.

A history of vomiting could suggest an undiagnosed eating disorder. If the woman reports vomiting to control weight gain, warn her of the risks imposed on the fetus if she continues to do it while pregnant. It's usually not very effective to focus on the risks she is imposing on herself.

## Body Image

If a woman greatly misinterprets her prepregnancy weight and body shape, she may try to resist appropriate weight gain. It is important to warn adolescents of the changes their bodies will undergo while being pregnant. If the woman has a weight phobia, remind her that it is important to eat healthy foods in order for her newborn to be healthy.

## Special Diets

The use of a special diet may indicate a chronic disease or condition requiring dietary treatment, self-imposed food restrictions, or eating behaviors based on religious or cultural beliefs. Dietary factors including milk allergies, lactose intolerance, self-imposed dietary restrictions, and inappropriate use of supplements and over-the-counter medications are important to note. Special diets may be beneficial,

FURTHER  
NUTRITIONAL  
ASSESSMENT IS  
USUALLY NEEDED  
FOR A WOMAN WHO  
FOLLOWS A SPECIAL  
DIET, DIETS OFTEN  
FOR WEIGHT LOSS,  
OR RESTRICTS HER  
DIETARY INTAKE FOR  
OTHER REASONS.

neutral, or harmful. Nutrition and health risks may be involved.

A woman who frequently or consistently restricts her dietary intake may have low nutrient reserves and start her pregnancy in poor nutritional health. Further nutritional assessment is usually needed for a woman who follows a special diet, diets often for weight loss, or restricts her dietary intake for other reasons. If the woman indicates she is on a special diet, ask her additional questions to learn more about her dieting behavior:

- *How long have you been on this diet?*
- *Who prescribed or recommended this diet?*

## Eating Nonfood Substances (Pica)

Pica is the compulsive eating of nonfood substances having little or no food value. When pica substances replace food, inadequate intake of nutrients may result. If calorie-containing substances are eaten in large amounts, pica may contribute to excessive weight gain. Paint chips, clay, and dirt may contain lead and starch, and clay may interfere with the absorption of certain minerals like iron. In addition, dirt and clay may contain parasites. Laundry starch is not manufactured as a food product and is high in bacteria.

Encourage the woman to stop pica behaviors but be sensitive to her cultural beliefs. Substitution of an appropriate food may be a helpful suggestion. For example, a woman can freeze fruit juice to eat instead of ice. If pica behaviors are associated with possible lead ingestion, refer the woman for blood testing.

## Food Supply and Resources

If the woman says she has difficulty obtaining food, ask her if she is participating in the WIC program or other food programs. If she is, find out if she has other problems that impact her ability to have an adequate supply of food.

If she is not obtaining enough food, encourage her to use food programs such as the WIC Program, Food Stamps, and food pantries.

If the woman does not have a functioning stove or refrigerator, she may need education on food purchasing, preparation, and storage. Contact your county UW-Extension office for more information.

# F Relationships

Women who do not have an adequate social support system need more intensive prenatal care coordination. Your role is to convince the woman of her worth and dignity and let her know that she is valued as much as her unborn child. Tell the woman that she may refuse to answer any of the questions if they become too painful to answer. It may take several meetings before the woman feels comfortable enough to respond to such personal questions.

## Emotional Response to Pregnancy

It is normal for a woman to have mixed feelings about being pregnant. It may be her first pregnancy, it may have been unplanned, she may not know how she will be able to support herself and a baby, or her partner may disapprove. If a woman answers that she is very upset, talking with her about her concerns will help you identify ways to assist her. Refer her for treatment as needed. A woman who is very upset about the pregnancy may make unhealthy decisions that can negatively affect the birth outcome.

## The Partner

If the woman says that her partner does not know that she is pregnant, it may suggest that she is afraid to tell him. If the woman says that her partner is very upset about the pregnancy, her personal safety might be a concern. Pregnant women are at an increased risk of spousal or partner abuse. All pregnant women should be screened for battering during routine medical prenatal assessments.

## Depression

A woman who admits to feeling depressed most or all of the time is in need of immediate attention. She may feel hopeless, incompetent, depressed, extremely isolated, suicidal, and without help and emotional support. As a result, she may turn to alcohol and other drugs in her attempt to cope with her problems. A battered woman may begin to use alcohol and other drugs as a means to cope with the

A WOMAN WHO ADMITS  
TO FEELING DE-  
PRESSED MOST OR  
ALL OF THE TIME IS IN  
NEED OF IMMEDIATE  
ATTENTION.

violence. Your role is to help her identify her problems, develop a care plan, and provide her with some hope for the future.

## Children in the Household

Finding out how many children are presently living in the expectant mom's household will help you understand the daily demands and responsibilities on her time at home. She may be caring for other children in addition to her own. In addition, you may learn that some of her children may live with other relatives or friends, in foster homes, or reside in other alternative home settings. This information will help you develop a workable care plan together.

## Risk for HIV

HIV can be transmitted from an infected woman to her fetus during pregnancy, during labor and delivery, and through breast-feeding. If the woman is HIV positive, she can dramatically decrease the chances of transmitting the disease to her unborn child if she receives treatment as early in her pregnancy as possible. Counseling and testing only targeted to women who report high-risk behaviors may fail to identify as many as 50-70 percent of HIV-infected women. The U.S. Public Health Service, Centers for Disease Control (CDC), recommends routine HIV counseling and voluntary testing for all pregnant women. Testing should be offered in a straightforward, informative, and non-judgemental manner. If HIV status has not been confirmed by the time of birth, voluntary postpartum testing should be encouraged.

COUNSELING AND  
TESTING ONLY  
TARGETED TO WOMEN  
WHO REPORT HIGH-  
RISK BEHAVIORS MAY  
FAIL TO IDENTIFY AS  
MANY AS 50 TO 70  
PERCENT OF HIV-  
INFECTED WOMEN.

Though the state statutes do not require the use of a separate HIV testing consent form, the statutes are very clear about the information which must be provided to a person so that an informed decision to consent is made. Refer to Attachment 8 for a sample form.

## Family Patterns of Alcohol or Drug Abuse

A partner who has an alcohol or drug problem creates a home environment that is unstable, unpredictable, and potentially violent. News of an unexpected pregnancy may prompt the partner to turn to alcohol or other drugs as a way to escape from the additional responsibility. A

woman who abuses substances may find it even harder to stop using or cut back considerably if her partner uses heavily. If the woman is keeping the pregnancy a secret, she may continue using alcohol and other drugs or “partying” with him.

The presence of alcohol and other drugs tends to increase the likelihood of domestic violence. Research shows that alcohol is present as a factor in a significant number of battering cases reported to police and woman’s shelters. Battering situations that involve alcohol tend to be more serious. Most abusers are multiple drug users, supplementing their primary drug of choice with alcohol. Refer to page 23 of this section for more information about the effects of alcohol use during pregnancy.

## Other Family Members

The behavior of anyone in the home environment will have an impact on everyone in the household. Relatives tend to keep the substance abuse a secret in an effort to “protect” the user and to bring security to an extremely insecure situation.

Be particularly attentive if the pregnant woman is an adolescent and identifies one or both of her parents or primary caregivers with an alcohol or drug problem. Blame, fear, and shame can pressure the woman to keep the secret. The connection between substance abuse and child abuse has been established.

## Abuse to the Woman

Abuse to women is found in all social, economic, ethnic, and racial groups. Battering often begins or escalates during pregnancy. Those women who are abused are twice as likely as women who are not abused to delay prenatal care. The risk of battering is greatest to a woman who:

- Has a higher occupation and educational status than her partner.
- Has a partner who is unemployed or consistently underemployed.
- Is physically isolated (rural residence).
- Is alienated from her family and friends.
- Has a language difference.
- Has physical limitations.

## Child Abuse and Neglect

Child abuse and neglect (that occurs to children under 18 years of age) includes physical injury, sexual intercourse or sexual contact, emotional abuse, and neglect for reasons other than poverty to provide necessary care, food, clothing, medical care, dental care, or shelter. Refer to Attachment 9 for a copy of Section 49.981 of the Wisconsin Child Abuse Neglect Act.

## Child Sexual Abuse

Child sexual abuse is defined as contact or interaction between a child and an adult when the child is being used for the sexual stimulation of the offender or another person. Wisconsin Statutes define “child” for legal purposes as any person under the age of 16 in sexual assault cases and under the age of 18 in fornication, enticement, sexual gratification, and pornography offenses. Incest is the sexual activity or sexual contact between family members such as brother and sister, father and daughter, mother and son, daughter and son and stepfather, etc.

## Domestic Abuse

Domestic abuse is a pattern of physical, sexual and/or emotional abusive behavior (known as battering) that occurs between an adult person against his or her spouse or former spouse, against an adult with whom the person resides or formerly resided, or against an adult with whom

THOSE WOMEN WHO ARE  
ABUSED ARE TWICE AS  
LIKELY AS NONABUSED  
WOMEN TO DELAY PRENATAL  
CARE.

the person has created a child. Most often domestic violence starts as an intimate relationship. Refer to Attachment 10 for information about the Domestic Violence Statutes. Refer to Attachment 11 for a list of Wisconsin Domestic Abuse Programs.

## Sexual Assault or Rape

This includes all forms of sexual victimization, including forcible rape, attempted rape, and other acts of unwanted sexual aggression.

The Wisconsin Child Abuse Neglect Act, Section 49.981, lists individuals who are required to report any suspected abuse or neglect or a belief that abuse or neglect will occur. It also explains the circumstances under which a health care provider is not required to report.

## **Forced Sexual Contact**

Most often children are sexually abused by adults they already know and trust, who often are members of their families, or close friends. Female incest victims tend to have a higher rate of alcohol and drug use because of low self-esteem, unresolved anger, and feelings of helplessness and hopelessness.

If other members of the woman's family have been sexually assaulted or abused, it is important for her to talk about it. This information may give you some insight into the woman's everyday life, social support network, and home environment.

If the woman fears anyone, including her partner, will abuse her, she is in need of immediate assistance. She will not admit to this unless she is truly scared.

## **Guns in the Home**

Inform the woman of the dangers of handguns in the home and encourage her to keep any guns in the home unloaded. Handgun owners are more likely to keep their guns loaded and fire their guns after drugs or alcohol are consumed. Explain to the woman that guns should be kept out of the reach and sight of children because they are too young to really understand the lethal potential of firearms.

## **Social Support**

The perception of an individual's social support system may, under certain circumstances, protect that individual from a variety of negative stressors. It is important for the woman to have at least one close contact to provide her with stable care and attention.

Mothers who report more social support bond with their children more readily and provide a more stimulating home environment.

When the woman tells you who she talks to, it will also lead to how she deals with her problems. Sharing this information with you will allow you to understand her strengths and develop a realistic care plan with her.



# G Worries

The woman may have additional worries or concerns that the questionnaire does not cover. The end of the questionnaire allows you to go over subjects the expectant mom needs more information about and allows you both to get to know each other better.

## Transportation

One major barrier for obtaining prenatal care, especially for those women who live in rural areas, is transportation. Assist the woman in arranging transportation if she does not have access to services. Transportation to Medicaid-covered services may be paid by Wisconsin Medicaid. Refer to Part Z, the prenatal care coordination services handbook, for more information.



# Attachment 1

## Pregnancy Questionnaire

Refer to the following pages for Attachment 1. Included is the updated version from 5/01.

This form consists of six (6) two-ply pages. This is page 1.

Agency Name: \_\_\_\_\_

Agency Telephone Number: \_\_\_\_\_

EDC: \_\_\_\_\_

## PREGNANCY QUESTIONNAIRE

### A. GENERAL INFORMATION

1. Mother's Name and Address: *(Please print)*

_____	_____	_____
Last Name	First	Middle
_____		
Street Address		
_____		
_____	_____	_____
City	State	Zip Code

2. Mother's date of birth: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Medicaid ID#: \_\_\_\_\_

5. Telephone number:  
(home) \_\_\_\_\_  
(work) \_\_\_\_\_  
No phone, or phone is often disconnected.

6. How can we contact you?  
Call home                      Call work  
Write home                     Other: \_\_\_\_\_

7. Are you:  
Single (never married, separated,  
divorced, widowed)  
Married

8. Your race/ethnic origin:  
White                              African-American  
Hispanic                          American Indian  
Southeast Asian                Other: \_\_\_\_\_

9. Do you speak English?  
Very well  
A little  
Not at all

10. Do you read English?  
Very well  
A little  
Not at all

11. Are you in a WIC Program?  
No                                  Location: \_\_\_\_\_  
Yes                                   I was denied  
I just applied                    I don't know about WIC

12. What are your sources of income? *(Please check all that apply.)*

Self	Parents
Partner/Spouse	Alimony
Child support payments	
Unemployment benefits	
Other: _____	

13. Are you employed?

No  
Yes

I am a student

If you are employed, what is your occupation?

If you are employed, how many hours do you usually work in a week? \_\_\_\_\_

14. What was the last grade you finished in school? \_\_\_\_\_

If in school now do you attend regularly?

No  
Yes

I am working on GED or have completed it.

15. Have you in the past, or are you currently, receiving special educational services or exceptional education services?  
No  
Yes

16. Where do you live?  
House/Mobile Home  
Apartment  
Homeless (includes shelter, hotel, motel)  
With other family members or friends

17. How many times have you moved in the last year?

\_\_\_\_\_

18. Name address, and telephone number of parent, guardian, or person to contact in an emergency:

\_\_\_\_\_

Street Address

\_\_\_\_\_

_____	_____	_____
City	State	Zip Code

Telephone number: \_\_\_\_\_

What relation is this person to you? \_\_\_\_\_

## B. ABOUT THIS PREGNANCY

1. How far along are you now?  
\_\_\_\_ weeks (or) \_\_\_\_ months  
I don't know
2. How far along were you when you started seeing a medical provider (doctor, nurse midwife or nurse practitioner) for prenatal care?  
\_\_\_\_ weeks (or) \_\_\_\_ months  
I haven't seen anyone yet  
I have an appointment
3. Have you seen your medical provider at least monthly for this pregnancy?  
No  
Yes
4. Did this pregnancy come less than a year after your last pregnancy?  
No  
Yes
5. Are you pregnant with more than one baby?  
No  
Yes  
I don't know
6. Have you had any early signs of labor?  
No  
Yes
7. Have you gone to the emergency room or hospital for this pregnancy?  
No  
Yes
8. Would you like more information or help with any of these things?  
The baby's growth  
How to eat right during pregnancy  
What to expect during labor and delivery  
Breastfeeding  
How to take care of your infant or older children  
Family planning  
Other: \_\_\_\_\_

## C. YOUR MEDICAL HISTORY

1. Do you have, or have you ever had any of these conditions? *(Please check the boxes that apply to you.)*  
Asthma and taking medication  
Chlamydia or gonorrhea (clap)  
Anemia (i.e., "low blood or iron" of pregnancy)  
Chronic kidney disease  
Diabetes  
Epilepsy or seizures  
Exposure to TB in your household  
Heart Disease  
Eating Disorder  
Hepatitis B  
High blood pressure during pregnancy (e.g., preeclampsia, toxemia)  
Kidney/bladder infections  
Mental health problems  
Physical or sensor disabilities (e.g., deaf or blind)  
Genetic disease (e.g., sickle cell, cystic fibrosis, PKU, hemophilia)  
Syphilis  
Genital herpes  
Other medical problem. If so, list them here:  
\_\_\_\_\_
2. How many times have you been pregnant before this pregnancy? \_\_\_\_ times  
Never
3. Have you had any miscarriages?  
No  
Yes \_\_\_\_ How many?
4. Have you had any abortions?  
No  
Yes \_\_\_\_ How many?  
*(If this is the first time you have ever been pregnant, skip the questions below and answer the questions in Part D. Thank you.)*
5. Have you had twins, or multiple births?  
No  
Yes
6. Have you ever had a C-section?  
No  
Yes

7. Were any of your babies born more than 3 weeks early?  
No  
Yes How many? \_\_\_\_\_
8. Did a doctor ever say you had premature labor that required bed rest, medication, and/or hospitalization?  
No  
Yes How many? \_\_\_\_\_
9. Have you had a stillborn baby (born dead after 20 weeks), or that died soon after birth?  
No  
Yes How many? \_\_\_\_\_
10. Did any of your babies weigh less than 5 pounds at birth?  
No  
Yes How many? \_\_\_\_\_

11. Did any weigh more than 10 pounds at birth?  
No  
Yes How many? \_\_\_\_\_
12. Did any stay more than one day in a special care nursery?  
No  
Yes How many? \_\_\_\_\_
13. When did you start prenatal care during your last pregnancy?  
I did not continue with that other pregnancy  
I did not get any prenatal care  
1st - 3rd month  
4th - 6th month  
7th - 9th month

#### D. TOBACCO, ALCOHOL, MEDICINES AND OTHER DRUGS

1. During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?  
More than 2 packs a day  
1 or 2 packs a day  
About a pack a day  
About a half pack a day  
About 4 or 5 cigarettes a day  
I don't smoke
2. On average, how many cigarettes do you smoke a day now?  
More than 2 packs a day  
1 or 2 packs a day  
About a pack a day  
About a half pack a day  
About 4 or 5 cigarettes a day (or 2 to 6)  
I live with someone who smokes  
I don't smoke

*We would like to ask you a few questions about drinking. It will help us take better care of you and your baby. Think back to 3 months **before** you became pregnant. Be sure to include beer, wine, and liquor in your answers to these questions.*

3. How many drinks does it take to make you feel high? \_\_\_\_\_ drinks  
I never drink
4. How much can you hold? \_\_\_\_\_ drinks  
I never drink  
I don't know

5. Have people annoyed you by criticizing your drinking?  
No  
Yes  
I never drink
6. Have you ever felt you ought to cut down on your drinking?  
No  
Yes  
I never drink
7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?  
No  
Yes  
I never drink
8. **Since you became pregnant**, about how many days in a month do you have 3 or more drinks?  
(If none, write zero.) \_\_\_\_\_ days per month
9. **Since you became pregnant**, about how many days in a month do you have one or more drinks?  
(If none, write zero.) \_\_\_\_\_ days per month
10. Have you taken any prescription drugs since you became pregnant?  
No  
Yes  
(Please list them here.)  
\_\_\_\_\_  
\_\_\_\_\_

11. Have you taken any over-the-counter drugs since you became pregnant?  
 No  
 Yes  
*(Please list them here.)*  
 \_\_\_\_\_  
 \_\_\_\_\_
12. Have you ever injected a non-prescribed drug?  
 No *(Skip to question 15)*  
 Yes
13. Number of different persons with whom you shared intravenous drug needles or syringes, or “works” within the last:  
 10 years \_\_\_\_\_ last 12 months \_\_\_\_\_
14. Do you think any of these persons were infected with HIV (the AIDS virus)?  
 No  
 Yes  
 I don’t know

15. How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant?  
*(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never
16. How often did you use cocaine or crack during the 3 months before you found out that you were pregnant?  
*(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never
17. How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc. during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never

## E. NUTRITION

1. How much did you weigh before you became pregnant this time? \_\_\_\_\_ pounds  
 How tall are you? \_\_\_\_\_ ft. \_\_\_\_\_ inches
2. What do you weigh now? \_\_\_\_\_
3. Have you ever vomited to control your weight or vomited to feel better after eating too much?  
 No  
 Yes
4. Do you vomit often now?  
 No  
 Yes
5. Are you having any of the following symptoms now:
- |              |    |     |
|--------------|----|-----|
| Nausea       | No | Yes |
| Heartburn    | No | Yes |
| Constipation | No | Yes |
6. When you were not pregnant, did you feel that your weight and your body shape were:  
 About right  
 Overweight/too large  
 Underweight/too small
7. Are you on a special diet **now**?  
 No  
 Yes Kind: \_\_\_\_\_
8. Do you eat corn starch out of the box, laundry starch, paint chips, lots of ice, clay, dirt or other things that are not food?  
 No  
 Yes
9. During the past month did you miss any meals or not eat when you were hungry because there wasn’t enough food or money to buy food?  
 No  
 Yes
10. Do you have a working stove and refrigerator?  
 No  
 Yes

## F. RELATIONSHIPS

1. How do you feel now about being pregnant?  
Very happy  
Unsure--a little bit happy and a little bit unhappy  
Very upset about it
2. How does your husband or partner feel now about you being pregnant?  
Very happy  
Unsure--a little bit happy and a little bit unhappy  
Very upset about it  
He doesn't know I'm pregnant
3. How often did you feel depressed during the last week?  
Rarely (less than 1 day)  
Some of the time (1-4 days)  
Most or all of the time (5-7 days)
4. How many living children do you have? \_\_\_\_\_
5. How many of them are living in your household now?  
\_\_\_\_\_
6. Within the last 12 months, have any of your children been taken from you?  
No  
Yes
7. Have you had sexual contact with any of following:  

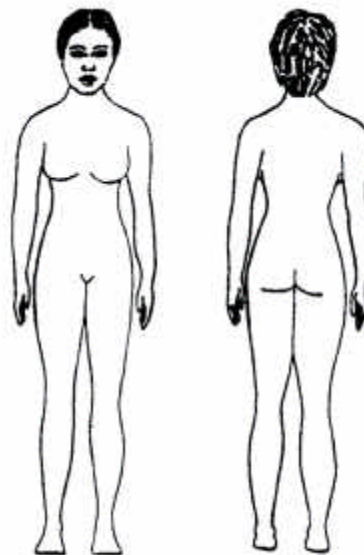
HIV Infected partner?	No	Yes	Not Sure
An IV drug user?	No	Yes	Not Sure
A bisexual partner?	No	Yes	Not Sure
A hemophiliac?	No	Yes	Not Sure
8. Have you given or received money or drugs for sex?  
No  
Yes
9. Does your partner have a problem with alcohol or other drugs?  
No  
Yes
10. Does anyone else in your family have a problem with alcohol or other drugs?  
No  
Yes

What relation is this person to you?

\_\_\_\_\_

11. Have you **ever** been emotionally, verbally or physically abused by your partner or someone close to you?  
No  
Yes
12. Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?  
No  
Yes
13. Since you have been pregnant, were you hit, slapped or kicked, or otherwise physically hurt by someone?  
No  
Yes  
If yes, by whom? \_\_\_\_\_

Mark the place on the picture of the woman to show where you have been hurt by your partner or someone close to you.



Adapted from the March of Dimes

14. Has anyone forced you to have sexual contact?  
No  
Yes  
If yes, by whom? \_\_\_\_\_

15. Have other family members been sexually assaulted or abused?

No  
Yes

16. Are you afraid of your partner or anyone else?

No  
Yes

17. Is there a gun in your home?

No  
Yes

18. Is there someone you can talk to when you have a problem?

No  
Yes

19. How many people can you really count on when you

need help?

No one

1 - 2 persons

3 or more persons

List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. What do you do to deal with your problems?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## G. WORRIES

1. Which of these things worry you a lot? (*Check the ones that are big problems.*)

Money problems

Labor and delivery

Transportation

Losing this baby

My job

Caring for this baby

My partner's job, or unemployment

Caring for my other children

Housing problems/getting evicted

Getting child care

My partner's drinking or drug use

My health

My own drinking or drug use

My own safety

Worry about my relationship with my partner

Worry whether this baby will be all right

My partner is in jail

2. How often do you have problems getting transportation?

Very seldom

Occasionally

Quite often

Most of the time

Please write down here anything else that worries you a lot:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Staff Signature/Date

Points (subtotal) \_\_\_\_\_

Total (all pages) \_\_\_\_\_

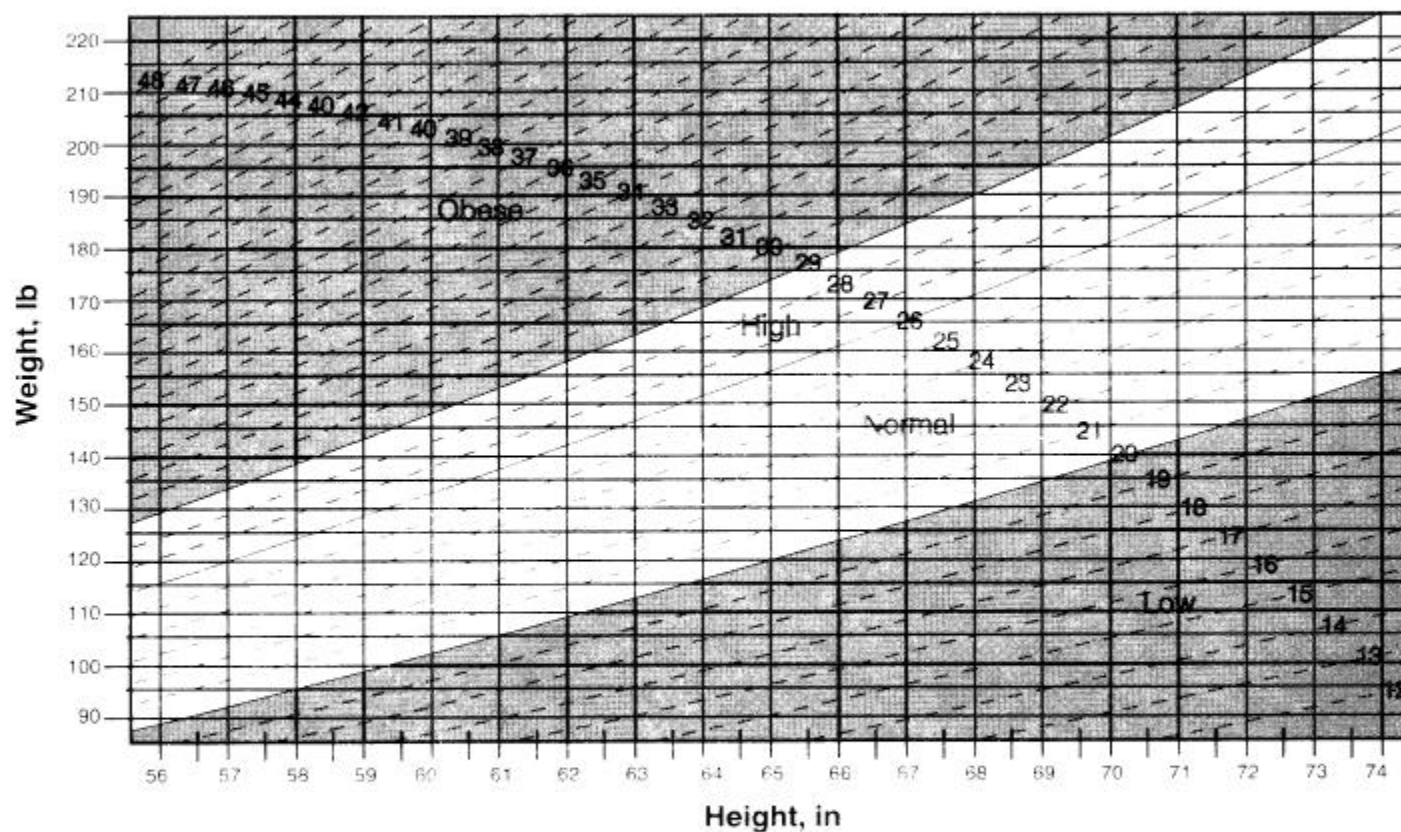
## Attachment 2

### Body Mass Index Grid

Refer to the following pages for Attachment 2.



## Chart for Estimating Body Mass Index (BMI) Category and BMI (Pounds and Inches) of Adult Women



### Directions

To find BMI Category (e.g., low, normal, etc.), find the point where the woman's height and weight intersect.  
To estimate BMI, read the bold number on the dashed line that is closest to this point.





## Attachment 3

### For More Information, Contact

**The Maternal and Child Health (MCH) Hotline:**  
**(800) 722-2295 or (800) 311-BABY or in Spanish (800) 504-7081.**

The MCH Hotline will direct you to local information sources regarding the following:

- Health care during pregnancy.
- Child health concerns.
- WIC program.
- HealthyStart program.

**Child abuse and neglect, reporting of:**

Your local county human or social service agency

**Cystic fibrosis:**

Cystic Fibrosis Center

Children's Hospital-Milwaukee and UW Children's Hospital-Madison

**Domestic abuse:**

Domestic Abuse Hotline (800) 787-3223

**Food preparation, storage, and purchasing of:**

County UW Extension office

**HIV/AIDS:**

Wisconsin Division of Health AIDS/HIV Program (608) 267-5278

Wisconsin AIDSline (800) 334-AIDS (Milwaukee (414) 273-AIDS)

**Hepatitis B:**

Division of Health Immunization Program (608) 267-9959

**Occupational hazards and pregnancy:**

Wisconsin Division of Health, Reproductive Hazards in the Workplace Program (608) 266-2074

**Phenylketonuria (PKU):**

PKU Clinic

Waisman Center- Madison, Children's Hospital- Milwaukee, and Marshfield Children's Hospital

**Sickle cell disease:**

Wisconsin Sickle Cell Disease Comprehensive Center (414) 257-1232

**Smoking cessation:**

American Cancer Society (800) 227-2345

American Lung Association (800) 242-5160

**Tuberculosis:**

Local Public Health Department

State TB Control Program (608) 266-9452

*Core Curriculum on Tuberculosis: What the Clinician Should Know* (Third Edition, 1994) CDC



## Attachment 4

### Estimated Date of Delivery (EDD)

While the average pregnancy is 280 days from the last menstrual period, it is normal to give birth anywhere from 37-42 weeks after your last period. Use this chart to determine your EDD. Locate the **boldfaced** number that represents the first day of your last menstrual period. The lightfaced number below it represents the expected delivery date.

Jan	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Jan	Nov	
Oct	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7			
Feb	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28				Feb	Dec	
Nov	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5						
Mar	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Mar	Jan	
Dec	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5			
Apr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		Apr	Feb	
Jan	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4				
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	May	Mar	
Feb	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4			
Jun	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		Jun	Apr	
Mar	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7				
Jul	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Jul	May	
Apr	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7			
Aug	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Aug	Jun	
May	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7	8			
Sep	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		Sep	Jul	
Jun	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7			
Oct	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Oct	Aug	
Jul	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7			
Nov	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		Nov	Sep	
Aug	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7			
Dec	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Dec	Oct	
Sep	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7			



## Attachment 5

### Medical Symptoms that May Affect Outcome of Pregnancy

#### Anemia

Anemia is a reduction in the amount of hemoglobin, the oxygen-carrying component of red blood cells, in the bloodstream. Symptoms include fatigue, weakness, irritability, headaches, increased need for sleep, and loss of concentration. Anemia may cause adverse pregnancy outcomes for infants and mothers (fetal death, low birth weight, prematurity, and intrauterine growth retardation). If the woman has anemia, encourage her to obtain appropriate diagnostic testing and medical care, further in-depth nutrition assessment, and education.

#### Asthma and Asthma Meds

Symptoms of asthma include shortness of breath, increased mucous secretions (caused by allergens, chemical irritants, drugs, exertions, infection, excitement, and cold air). A woman with severe symptoms may deliver a low birth weight baby. Asthma medications are usually safe to take during pregnancy. If the woman has asthma, develop a plan with her health care provider to help her recognize and avoid those situations that trigger an attack.

#### Chlamydia or Gonorrhea (clap)

Chlamydia and gonorrhea (clap) are the most common sexually transmitted diseases in the United States. A woman with one of these diseases may have preterm labor, pelvic inflammatory disease, and increased risk for ectopic pregnancy or sterility. The disease can also spread to the baby at birth and the baby is at risk for pneumonia or blindness. If the woman has one of these diseases, refer her to a health care provider and follow up on her diagnosis and treatment.

#### Chronic Kidney Disease

If the woman has renal disease that progresses and function declines, the ability to sustain the pregnancy declines. To ensure that the woman receives adequate treatment, frequently contact members of her health care team. The team should include a nephrologist,

obstetrician, a clinical nutritionist, and a skilled obstetrical nurse. Care for the woman should involve diet management and planning for adequate rest.

#### Cystic Fibrosis

Cystic fibrosis primarily affects non-Hispanic whites. Symptoms include chronic respiratory infections and poor digestion. The woman is at increased risk for low weight gain. Make sure the woman meets special nutritional needs.

#### Diabetes

Diabetes is a condition that results when the body cannot make or use adequate insulin which is needed to properly metabolize carbohydrates and fats in food and maintain proper blood glucose (sugar) levels. During pregnancy, the diabetic woman may experience more difficulty in controlling blood glucose levels, increased urinary tract infections, and excessive amniotic fluid.

If the condition is well-controlled, the risks for mother and infant are reduced, but there is a risk for miscarriage. If the condition is poorly controlled, the infant is more likely to have a high birth weight, respiratory problems, congenital abnormalities, neonatal hypoglycemia, hyperbilirubinemia, or be stillborn. Encourage the woman to carefully monitor her blood glucose levels, dietary intake, and insulin or other medications throughout her pregnancy. Give the woman information on how to deal with hypoglycemia. All diabetic women should wear a "Medical Alert" bracelet or necklace.

#### Down's Syndrome

Down's syndrome is caused by a genetic defect. It is not an inherited disease. Instead of two number 21 chromosomes, a person with Down's syndrome has three. If there is a family history of Down's syndrome or the woman is older than 35, there is a higher risk that the infant will have it. Prenatal testing is usually offered to women who are 35 or older and who have had other children with chromosome disorders.

## Eating Disorders

A woman with *anorexia nervosa* has a distorted body image, inability to eat, and extreme fear of being fat. If the woman is anorexic, she may remain underweight throughout pregnancy.

A woman with *bulimia nervosa* has an uncontrollable intake of huge amounts of food (binging) followed by self-induced vomiting and laxative abuse. If the woman is bulimic, she may have an abnormal weight gain pattern and an adverse biochemical environment for the fetus.

If the woman has one of these conditions, she should receive special obstetrical care that includes services of a therapeutic dietician who works with the woman's physician in assessing nutritional status and needs and weight gain goals and who supports the woman to eat appropriately.

## Epilepsy or Seizures

Epilepsy or seizures can lead to a complex set of symptoms including abnormal electrical charges occurring in the brain. If the woman has epilepsy or seizures, she may experience episodes of unconsciousness, altered state of consciousness, muscular spasms, and other behavior alterations. If the woman is closely monitored by her health care provider, good birth outcomes are probable. Physicians will alter medications so they won't harm the fetus. A pregnant woman *should not* increase, decrease, or stop taking her medication. Give information to the woman to help her understand the condition as it relates to her pregnancy and new role as a parent.

## Heart Disease

Heart disease includes symptoms such as severe shortness of breath, faintness with exertion, or chest pain related to exertion. Babies are at increased risk of being small in size and premature. If the woman has congenital heart disease, the baby has an increased risk for inheriting the condition as well. Make sure the woman is referred for a genetic evaluation. Also reinforce the medical prenatal care plan that may include the prevention of excessive weight gain, abnormal fluid retention, anemia or infection, and increased rest periods.

## Hemophilia

Hemophilia is a condition when the blood lacks a substance needed for clotting. Women rarely have hemophilia disease but may be carriers of the trait. If the woman is a carrier, there is a 50 percent chance that her male child will have hemophilia disease. If the woman has a family history of hemophilia, refer her to a genetics counselor.

## Hepatitis B (HBsAg)

Hepatitis B is a liver disease caused by the Hepatitis B virus that is transmitted through exposure to infective body fluids (blood, semen, vaginal fluids, and saliva). If the woman is HBsAg-positive and HBeAg-positive, there is a 70 to 90 percent risk of transmitting it to the infant. These infants have a 5 to 10 percent risk of obtaining it prenatally and the remainder are infected at the time of delivery. Prenatal HBsAg testing of all pregnant women is now recommended. Infants born to HBsAg-positive mothers should receive doses of Hepatitis B vaccine and HBIG within 12 hours of birth or as soon as the mother is found out to be infected.

## High Blood Pressure (Hypertension, Pregnancy-Induced Hypertension)

High blood pressure is the result of blood pressure in the arteries being greater than normal. Symptoms include elevated blood pressure, sudden weight gain (greater than 1 lb/day), constant or severe headaches, blurred vision or spots in front of eyes, pain in upper right part of abdomen, and swelling in the face. If the symptoms are neglected or not treated properly, the condition may become life threatening quickly. A pregnant woman may experience convulsions or a stroke. Blood flow to the placenta decreased as much as 50 percent causes the fetus to be deprived of oxygen and nutrients. Assist the woman to follow nutritional requirements. Bed rest is frequently recommended. Ensure appropriate medical care, in-depth nutrition assessment and counseling, monitoring of blood pressure, and adequate rest. Daily home visits may be necessary.

## Kidney/Bladder infections

Kidney and bladder infections are common during pregnancy. Symptoms of bladder infections include frequent urination, burning, pain during urination, discomfort in the lower abdomen, and sometimes blood

in the urine. Symptoms of kidney infections include chills, fever, nausea or vomiting. Untreated kidney infections may be life threatening to the mother and are associated with preterm labor. Prompt medical treatment or hospitalization is required.

## Mental Health Problems

A woman with a history of mental health problems may require more time intensive care coordination. If the woman has a history of suicide attempts, she should be put in direct contact with her mental health provider. Asking the woman about her prescription use may reveal treatment for depression, anxiety, schizophrenia, or other mental health problems. A woman taking medication for her condition should continue to do so unless directed otherwise by her health care provider.

## Phenylketonuria (PKU)

Phenylketonuria (PKU) is caused by the lack of the enzyme that metabolizes phenylalanine, an amino acid in protein. If it is not treated, it may build up, and brain development can be severely affected resulting in mental retardation. High levels of phenylalanine can have very harmful effects on a developing fetus. A woman with PKU needs to follow the nutritional regime before conception and remain on the diet throughout her pregnancy. A woman with an elevated phenylalanine level should be immediately referred to a PKU clinic.

## Physical or Sensory Disabilities

A woman with physical or sensory disabilities may require more time-intensive care coordination. Work closely with her interpreter or health care provider. Refer her to an interpreter as soon as possible if she does not have one.

## Sickle Cell Disease

Sickle cell disease primarily affects people of African descent. A woman with the disease may experience anemia, preterm labor, growth retardation, or stillbirth. Ensure specialized prenatal care that can manage anemia and prevent or reduce sickle cell crises during pregnancy. Assess the woman for frequency of infections and assurance of adequate folic acid intake. A Hemoglobin Electrophoresis is recommended for all women of African descent.

## Tuberculosis (TB)

Tuberculosis is a bacterial infection that primarily affects the lungs, but may also involve the kidneys and other body systems. A skin test is the only way to tell if the woman has been infected and the disease is dormant. If the woman has pulmonary TB, she will have a productive cough, weight loss, night sweats, fatigue, fever, and hemotysis. If it is recognized and treated promptly, it will not have a damaging effect on the pregnancy. Antibiotics are administered throughout the pregnancy. The side effects of the medication are of some concern but it may be better than not treating the woman at all.

All possible cases of TB must be reported to the local health department or the State TB Control Program as soon as possible. Inform the woman of medication side effects and thoroughly explain the need for treatment.



## Attachment 6

### First Priority for Alcohol and Other Drug Abuse Treatment Services for Pregnant Women

Refer to the following pages for Attachment 6.





State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEALTH  
MAIL ADDRESS  
1 WEST WILSON STREET  
P.O. BOX 309  
MADISON, WI 53701-0309

Date: November 20, 1992

TO: AODA Coordinators  
AODA Treatment Providers  
Area Administrators/Assistant Area Administrators  
Bureau/Office Directors-DOH/DCS  
Bureau of Public Health Regional Office Directors  
County Departments of Community Programs Directors  
County Departments of Developmental Disabilities Service Directors  
County Departments of Human Service Directors  
County Departments of Social Service Directors  
High Risk Pregnancy-AODA Projects  
Local Public Health Agencies  
Maternal and Child Health Funded Projects  
Program Office Directors/Section Chiefs  
Tribal Chairpersons/Human Service Facilitators

FROM: Ann Haney, Administrator, Division of Health  
Gerald Born, Administrator, Division of Community Services

RE: First Priority for Alcohol and Other Drug Abuse Treatment Services for Pregnant Women

The purpose of this memo is to assure that pregnant women have first priority for alcohol and drug abuse treatment as required by law (1989 Wisconsin Act 122). Permanent rules went into effect on November 11, 1990. Attached is a signed copy of the permanent rules.

We believe that only through the collective efforts of people and organizations will we be able to prevent the devastating consequences of maternal alcohol and other drug use. As a result, it is critical that you, your staff and your colleagues in the community be fully aware of this law, and integrate it into ongoing programs and services.

According to the Task Force to Combat Alcohol and Other Drug Use by Pregnant Women and Mothers of Young Children, June, 1991, "...drug use by pregnant women is increasing. Most cases of drug use among pregnant women go undetected. As a result, substance use during pregnancy continues to be one of the most commonly missed of all obstetric and neonatal diagnoses. The widespread use of alcohol and other drugs in pregnancy and the failure to identify and treat maternal substance use contribute to high rates of infant morbidity and mortality in Wisconsin and threatens to undermine gains made by other programs to reduce these rates."

Providing first priority treatment for pregnant women is one of many important steps we can take as state and local agencies to promote healthy Wisconsin families and communities.

-Over-

For further information please contact:

DHSS-Division of Health-Bureau of Public Health

Richard Aronson, MD, Maternal and Child Health Director (608) 266-5818

-or-

Division of Community Services-Office of Alcohol and Drug Use

John Vick, Chief, (608) 266-1987

Attachment

ORDER OF THE  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
AMENDING AND CREATING RULES

To amend HSS 61.52(7)(b) and to create HSS 61.51(5m), relating to giving first priority for alcohol and other drug abuse (AODA) treatment services to pregnant women.

Analysis Prepared by the Department of Health and Social Services

Pregnant women who abuse alcohol or a prescription or over-the-counter drug or use cocaine or another illicit drug often give birth to children who have serious physical, mental or emotional problems resulting from the alcohol or drug use. Early referral of a pregnant women who has an abuse problem for treatment of that problem and then prompt treatment are important for the mother, the child and society. However, many alcohol and drug abuse (AODA) treatment facilities and agencies have waiting lists of persons seeking treatment so that at least some pregnant women referred for help with an abuse problem cannot get timely assistance.

Section 51.42(3)(ar)4m and (7)(b)7m, Stats., as created by 1989 Wisconsin Act 122, requires the Department to ensure that when there are not enough alcohol and other drug abuse (AODA) treatment services available to meet the needs of everyone eligible for those services, pregnant women are given "first priority" for receipt of those services. The Department is directed to define, by rule, what "first priority" for treatment means. This is done through this rulemaking order. "First priority" is defined in such a way that a pregnant woman assessed as needing AODA treatment services will be immediately referred to an available treatment provider and, if there is a waiting list for the services of that provider, will be placed on that waiting list immediately ahead of any person who is not entitled to "first priority" for services.

The Department's authority to amend and create these rules is found in s. 51.42(7)(b)7m, Stats., as created by 1989 Wisconsin Act 122, and s. 3023(2)(a) of 1989 Wisconsin Act 122. The rules interpret s. 51.42(3)(ar)4m and (7)(b)7m, Stats., as created by 1989 Wisconsin Act 122.

SECTION 1. HSS 61.51(5m) is created to read:

HSS 61.51(5m). "First priority for services" means that an individual assessed as needing services will be referred immediately to available treatment resources and that, in the event there is a waiting list for any treatment resource, will be placed on the waiting list immediately before any person not entitled to first priority for services.

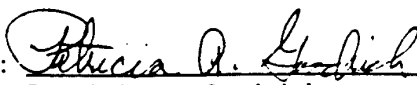
SECTION 2. HSS 61.52(7)(b) is amended to read:

HSS 61.52(7)(b). Criteria for determining the eligibility of individuals for admission shall be clearly stated in writing, with first priority for services given to pregnant women who are alcohol or drug abusers.

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22(2), Stats.

Wisconsin Department of Health  
and Social Services

Date: September 10, 1990

By:   
Patricia A. Goodrich  
Secretary

SEAL:

## Attachment 7

### Weight Gain Grids

Refer to the following pages for Attachment 7.



## PRENATAL WEIGHT GAIN GRIDS

(Information gathered on this form is needed for WIC Certification)

### Body Mass Index (BMI) and Weight

Height	Low (BMI <20)	High (BMI >26)	Obese (BMI >29)
4'8" (56")	<88 lbs.	>116 lbs.	>129 lbs.
4'9" (57")	<93 lbs.	>120 lbs.	>134 lbs.
4'10" (58")	<96 lbs.	>124 lbs.	>138 lbs.
4'11" (59")	<99 lbs.	>128 lbs.	>144 lbs.
5'0" (60")	<103 lbs.	>133 lbs.	>148 lbs.
5'1" (61")	<106 lbs.	>138 lbs.	>153 lbs.
5'2" (62")	<109 lbs.	>143 lbs.	>158 lbs.
5'3" (63")	<113 lbs.	>147 lbs.	>163 lbs.
5'4" (64")	<117 lbs.	>152 lbs.	>169 lbs.
5'5" (65")	<121 lbs.	>156 lbs.	>174 lbs.
5'6" (66")	<124 lbs.	>161 lbs.	>180 lbs.
5'7" (67")	<128 lbs.	>166 lbs.	>185 lbs.
5'8" (68")	<132 lbs.	>171 lbs.	>191 lbs.
5'9" (69")	<136 lbs.	>176 lbs.	>196 lbs.
5'10" (70")	<139 lbs.	>182 lbs.	>203 lbs.
5'11" (71")	<143 lbs.	>187 lbs.	>208 lbs.
6'0" (72")	<147 lbs.	>192 lbs.	>214 lbs.
6'1" (73")	<152 lbs.	>197 lbs.	>220 lbs.
6'2" (74")	<156 lbs.	>203 lbs.	>226 lbs.

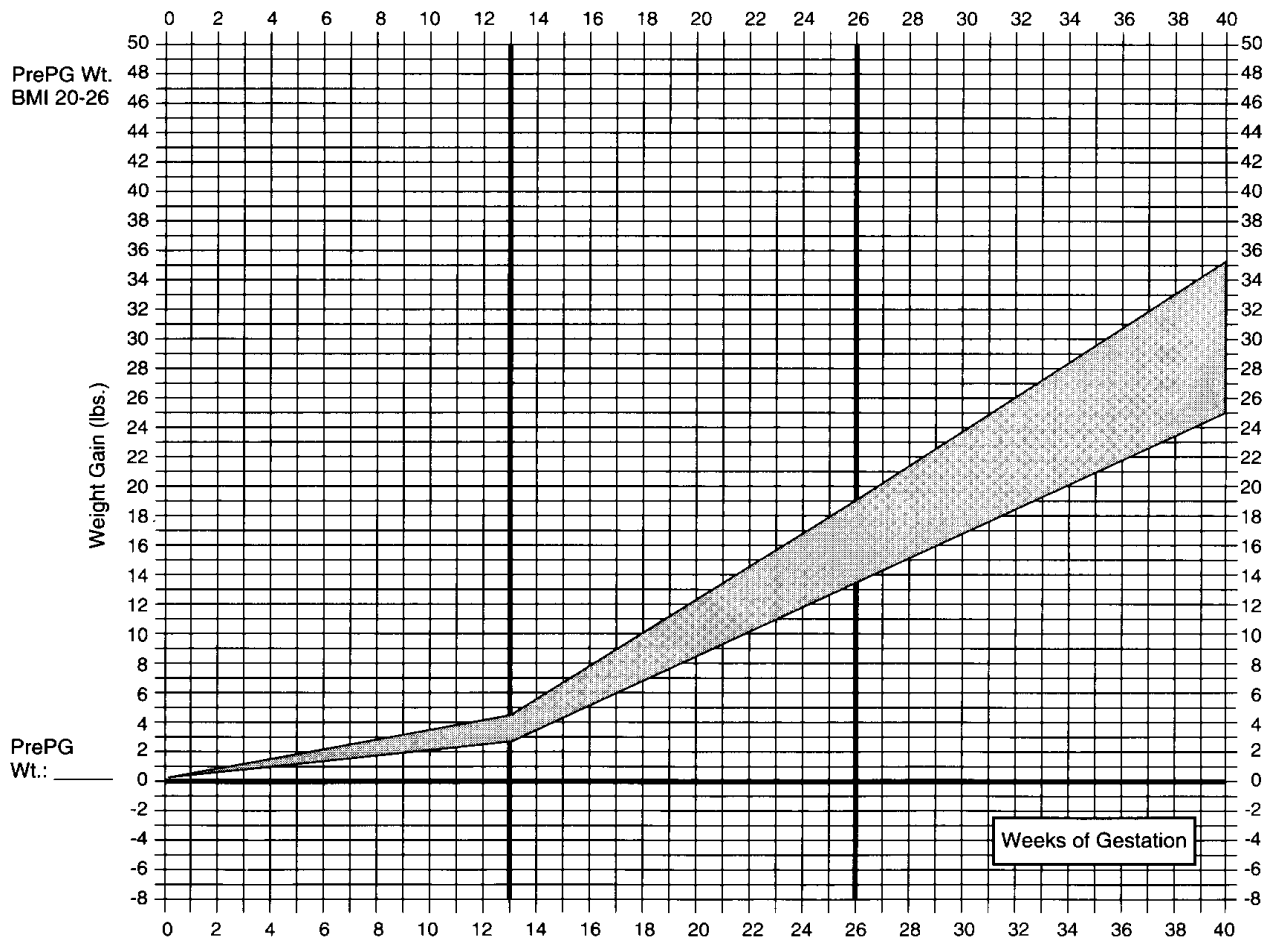
### Directions:

Using the table to the left, assess the woman's pregravid weight for her height as normal (Body Mass Index 20-26), low (BMI <20), high (BMI >26-29), or obese (BMI >29). Select the appropriate weight gain grid. Write the woman's pregravid weight on the blank line to the left of the zero on the side of the grid. (The "zero" line represents her pregravid weight.) At woman's current week gestation, plot her current weight. Next to the plot, you may wish to write the date and weight. If prepregnancy weight is unknown, use your best judgment to select the appropriate grid. At the woman's current weeks gestation, plot the current weight at the mid-point of the shaded area; at next visit, count lbs. gained or lost from that point.

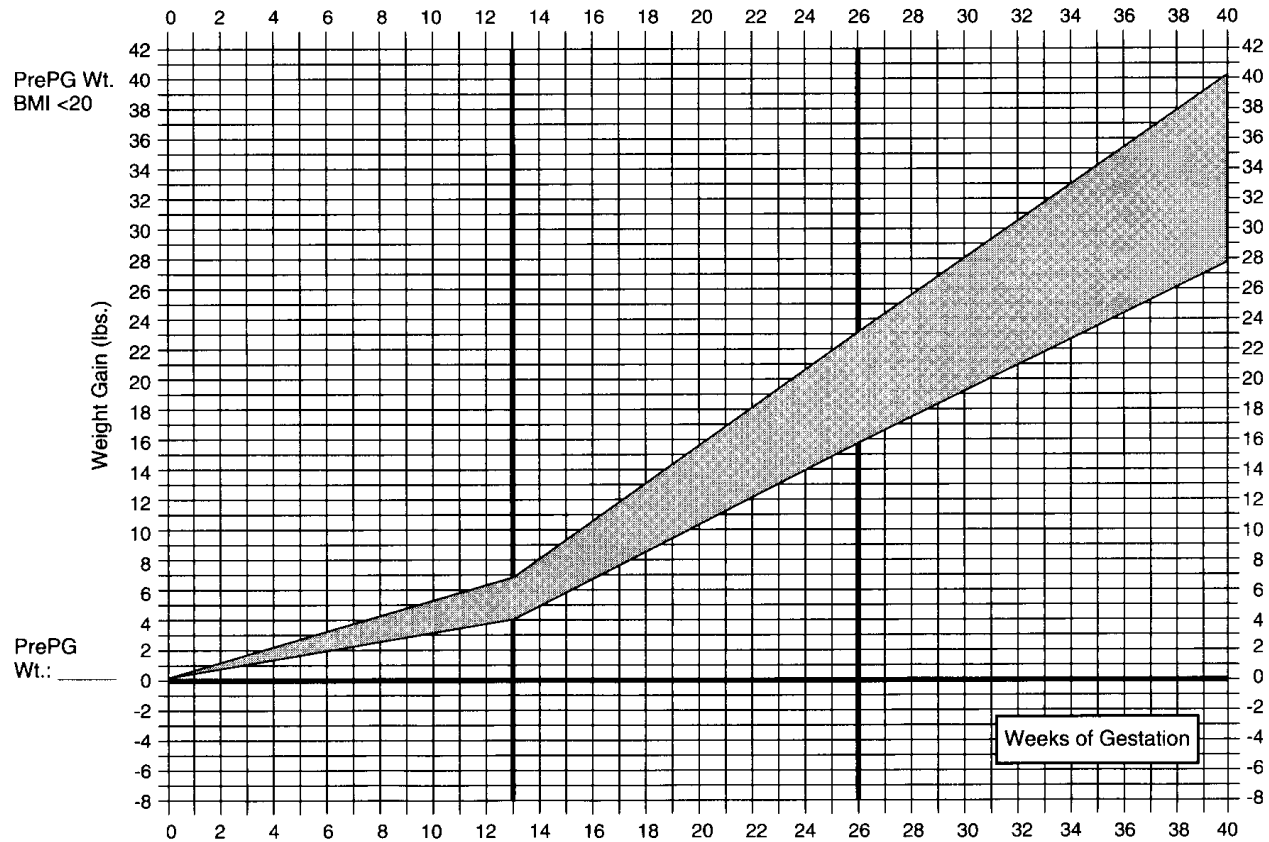
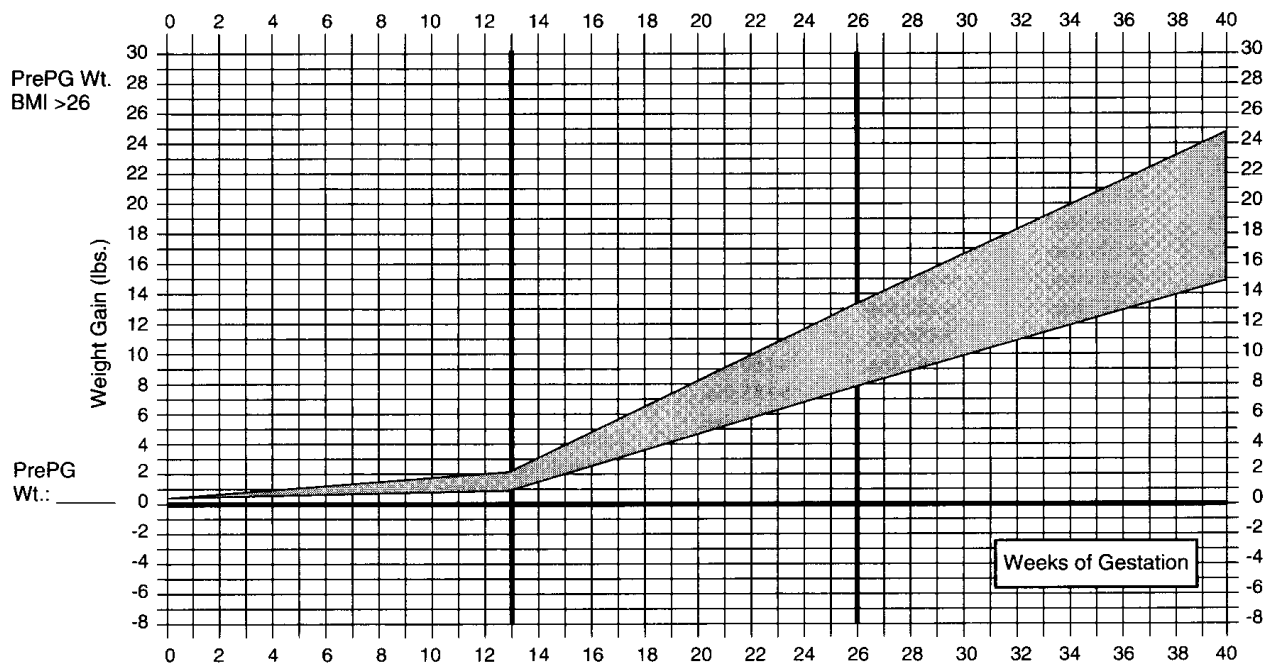
### Weight Gain Recommendations:

Low weight: 28-40 lbs. (twins: 38-50)  
Normal weight: 25-35 lbs. (twins: 35-45)  
High weight: 15-25 lbs. (twins: 25-35)  
Obese: at least 15 lbs. (twins: approx. 25)  
Adolescents: at least upper end of recommended gain  
Black women: upper end of recommended gain  
Short women: at least lower end of recommended gain

Name \_\_\_\_\_ Certification Date: \_\_\_\_\_ EDC: \_\_\_\_\_



Name \_\_\_\_\_ Certification Date: \_\_\_\_\_ EDC: \_\_\_\_\_



## Attachment 8

### CONSENT TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)

1. I have been asked for consent to test the blood of \_\_\_\_\_.  
(name)
2. I understand the following regarding HIV testing:
  - Benefits of testing.
  - Potential for false positive and negative results.
  - Potentially harmful psychological impact of a positive result.
  - Importance of additional/future testing to rule out infection.
  - Resources and assistance available should the test be positive.
3. I have been informed that the HIV test results are confidential and shall not be released without written permission, except to the persons or organizations which have been given access by state law (a list is available upon request). I have been informed that these persons and organizations are also required by state law to keep these test results confidential.
4. I acknowledge that:
  - 1) I have read this consent form.
  - 2) I have been given the opportunity to ask questions concerning the blood test for HIV infection.
  - 3) My questions have been answered to my satisfaction.
5. I give my consent to have a blood sample obtained and tested for the presence of HIV infection.
6. I also authorize the following person(s) access to the HIV test results. *If applicable, give name and persons and time period (6 months, 1 year, etc.). If not applicable, cross out.*

Name of Person or Organization Authorized Access to Test Results

Time Period Authorized

Name of Person or Organization Authorized Access to Test Results

Time Period Authorized

\_\_\_\_\_  
Signature of Person Tested

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Other Legally Authorized Person (if Applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Person Tested

\_\_\_\_\_  
Relationship to Person Tested

\_\_\_\_\_  
Date

<p style="text-align: center;">PERSONS HAVING ACCESS TO RESULTS OF HIV TESTING BY LAW (WISCONSIN STATUTE SECTION 252.15)</p>
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1. the subject of the test: and, if the subject is incapacitated, the health care agent designated in a power of attorney form;

2. the subject's health care provider, including a health care provider who provides emergency care to the subject;

3. an agent or employee of the test subject's health care provider, who provides patient care or handles or process specimens of body fluids or tissues or prepares or stores patient health care records;

4. a blood bank, blood center or plasma center that subjects a person to a test;

5. a health care provider who procures, processes, distributes or uses a human body part for the purpose of assuring medical acceptability of the donated body part for the purpose intended;

6. the State Epidemiologist or his/her designee for the purpose of providing epidermal surveillance or investigation or control of communicable diseases;

7. a funeral director or to other persons who prepare the body of a decedent for burial or other disposition; or to a person who performs or assisting an autopsy;

8. health care facility staff committees or accreditation or health care services review organizations for the purpose of conducting program monitoring and evaluation and health care services reviews;

9. under lawful order of a court of record;

10. a person who conducts research, for the purpose of research, if the researcher:

- a) is affiliated with the test subject's health care provider,
- b) has obtained permission to perform the research from an institutional review board,
- c) provides written assurances that the use of the information requested is only for the purpose under which it is provided to the researcher. The information will not be released to a person not connected with the study, and the final research product will not reveal information that may identify the test subject unless the researcher has first received informed consent for disclosure from the test subject.

A private pay patient may deny researchers access to disclosure of his/her test results if he/she annually

submits to the maintainer of his/her test results a signed written request that denial be made.

11. persons rendering emergency care to a victim if a physician certifies the emergency caregiver has been significantly exposed;

12. a coroner or medical examiner or appointed assistant if:

- a) the HIV-infected status is relevant to determination of cause of death
- b) during direct investigation the coroner, medical examiner or appointed assistant is significantly exposed to the subject and a physician so certifies in writing;

13. a sheriff; jailer; keeper of a prison, jail or house of correction; or persons designated by them with custodial authority for the purpose of permitting private cell assignments;

14. persons known by the attending physician to have had sexual contact or shared intravenous drug paraphernalia with a patient while alive and the patient is now deceased;

15. the person who provides consent for testing an individual who is adjudicated incompetent, is under 14 years of age or is unable to communicate because of a medical condition;

16. an alleged victim or victim of sexual assault, the victim or alleged victim's parent or guardian and the victim or alleged victim's health care provider;

17. to an affected person who is significantly exposed;

18. to an agency directed to prepare a court report regarding a child recommended for placement in a foster home, group home or child caring institution, to the child's foster parent or operator of the group home or child caring institution if the child's parent or guardian so consents to testing and disclosure.

DOH 4544 (01/95)

# Attachment 9

## Wisconsin Child Abuse Neglect Act

### **48.981 Abused or neglected children. (1) DEFINITIONS.**

In this section:

(a) “Abuse” means any of the following:

1. Physical injury inflicted on a child by other than accidental means.
2. Sexual intercourse or sexual contact under s. 940.225, 948.02 or 948.025.
3. A violation of s. 948.05.
4. Permitting, allowing or encouraging a child to violate s. 944.30.
5. Emotional damage.
6. A violation of s. 948.055.

(am) “Caregiver” means, with respect to a child who is the victim or alleged victim of abuse or neglect or who is threatened with abuse or neglect, any of the following persons:

1. The child’s parent, grandparent, stepparent, brother, sister, stepbrother, stepsister, half brother or half sister.
2. The child’s guardian.
3. The child’s legal custodian.
4. A person who resides or has resided regularly or intermittently in the same dwelling as the child.
5. An employee of a residential facility or child caring institution in which the child was or is placed.
6. A person who provides or has provided care for the child in or outside of the child’s home.
7. Any other person who exercises or has exercised temporary or permanent control over the child or who temporarily or permanently supervises or has supervised the child.
8. Any relative of the child other than a relative specified in subd. 1.

(b) “Child” means any person under 18 years of age.

(cm) “Emotional damage” means harm to a child’s psychological or intellectual functioning which is exhibited by severe anxiety, depression, withdrawal or outward aggressive behavior, or a combination of those behaviors, and for which the child’s parent, guardian or legal custodian has failed to obtain the treatment necessary to remedy the harm. “Emotional damage” may be demonstrated by a substantial and observable change in behavior, emotional response or cognition that is not within the normal range for the child’s age and stage of development.

(cs) “Indian child” means any unmarried person who is under the age of 18 years and is affiliated with an Indian tribe or band in any of the following ways:

1. As a member of the tribe or band.
2. As a person who is both eligible for membership in the tribe or band and is the biological child of a member of the tribe or band.

(d) “Neglect” means failure, refusal or inability on the part of a parent, guardian, legal custodian or other person exercising temporary or permanent control over a child, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child.

(e) “Physical injury” includes but is not limited to lacerations, fractured bones, burns, internal injuries, severe or frequent bruising or great bodily harm as defined under s. 939.22 (14).

(f) “Record” means any document relating to the investigation, assessment and disposition of a report under this section.

(fm) “Relative” means a parent, grandparent, stepparent, brother, sister, first cousin, 2nd cousin, nephew, niece, uncle, aunt, stepgrandparent, stepbrother, stepsister, halfbrother, halfsister, brother-in-law, sister-in-law, stepuncle or steppaunt.

(g) “Reporter” means a person who reports suspected abuse or neglect or belief that abuse or neglect will occur under this section.

(h) “Subject” means a person named in a report or record as either of the following:

1. A child who is the victim or alleged victim of abuse or neglect or who is threatened with abuse or neglect.
2. A person who is suspected of abuse or neglect or who has been determined to have abused or neglected a child.

(i) “Tribal agent” means the person designated under 25 CFR 23.12 by an Indian tribe or band to receive notice of involuntary child custody proceedings under the Indian child welfare act, 25 USC 1901 to 1963.

(2) **PERSONS REQUIRED TO REPORT.** A physician, coroner, medical examiner, nurse, dentist, chiropractor, optometrist, acupuncturist, other medical or mental health professional, social worker, marriage and family therapist, professional counselor, public assistance worker, school teacher, administrator or counselor, mediator under s. 767.11, child care worker in a day care center or child caring institution, day care provider, alcohol or other drug abuse counselor, member of the treatment staff employed by or working under contract with a county department under s. 46.23, 51.42 or 51.437, physical therapist, occupational therapist, speech-language pathologist, audiologist, emergency medical technician or police or law enforcement officer having reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected or having reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect and that abuse or neglect of the child will occur shall, except as provided under sub. (2m), report as provided in sub. (3). Any other person, including an attorney, having reason to suspect that a child has been abused or neglected or reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may make such a report. No person making a report under this subsection may be discharged from employment for so doing.

**NOTE:** Sub. (2) is amended eff. 7-1-95 by 1993 Wis. Act 443 to read:

(2) **PERSONS REQUIRED TO REPORT.** A physician, coroner, medical examiner, nurse, dentist, chiropractor, optometrist, acupuncturist, other medical or mental health professional, social worker, marriage and family therapist, professional counselor, public assistance worker, school teacher, administrator or counselor, mediator under s. 767.11, child care worker in a day care center or child caring institution, day care provider, alcohol or other drug abuse counselor, , member of the treatment staff employed by or working under contract with a county department under s. 46.23, 51.42 or 51.437, physical therapist, occupational therapist, dietician, speech-language pathologist, audiologist, emergency medical technician or police or law enforcement officer having reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected or having reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect and that abuse or neglect of the child will occur shall, except as provided under sub. (2m), report as

provided in sub. (3). Any other person, including an attorney, having reason to suspect that a child has been abused or neglected or reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may make such a report. No person making a report under this subsection may be discharged from employment for so doing.

(2m) EXCEPTION TO REPORTING REQUIREMENT. (a) The purpose of this subsection is to allow children to obtain confidential health care services.

(b) In this subsection:

1. "Health care provider" means a physician, as defined under s. 448.01 (5), a physician assistant, as defined under s. 448.01 (6), or a nurse holding a certificate of registration under s. 441.06 (1) or a license under s. 441.10 (3).

2. "Health care service" means family planning services, pregnancy testing, obstetrical health care or screening, diagnosis and treatment for a sexually transmitted disease.

(c) Except as provided under pars. (d) and (e), the following persons are not required to report as suspected or threatened abuse, as defined under sub. (1) (a) 2., sexual intercourse or sexual contact involving a child:

1. A health care provider who provides any health care service to a child.

4. A person who obtains information about a child who is receiving or has received health care services from a health care provider.

(d) Any person described under par. (c) 1. or 4. shall report as required under sub. (2) if he or she has reason to suspect any of the following:

1. That the sexual intercourse or sexual contact occurred or is likely to occur with a caregiver.

2. That the child suffered or suffers from a mental illness or mental deficiency that rendered or renders the child temporarily or permanently incapable of understanding or evaluating the consequences of his or her actions.

3. That the child, because of his or her age or immaturity, was or is incapable of understanding the nature or consequences of sexual intercourse or sexual contact.

4. That the child was unconscious at the time of the act or for any other reason was physically unable to communicate unwillingness to engage in sexual intercourse or sexual contact.

5. That another participant in the sexual contact or sexual intercourse was or is exploiting the child.

(e) In addition to the reporting requirements under par. (d), a person described under par. (c) 1. or 4. shall report as required under sub. (2) if he or she has any reasonable doubt as to the voluntariness of the child's participation in the sexual contact or sexual intercourse.

(3) REPORTS; INVESTIGATION. (a) *Referral of report.* A person required to report under sub. (2) shall immediately inform, by telephone or personally, the county department or the sheriff or city, village or town police department of the facts and circumstances contributing to a suspicion of child abuse or neglect or to a belief that abuse or neglect will occur. The sheriff or police department shall within 12 hours, exclusive of Saturdays, Sundays or legal holidays, refer to the county department all cases reported to it. The county department may require that a subsequent report be made in writing. Each county department shall adopt a written policy specifying the kinds of reports it will routinely report to local law enforcement authorities.

(b) *Duties of local law enforcement agencies.* 1. Any person reporting under this section may request an immediate investigation

by the sheriff or police department if the person has reason to suspect that a child's health or safety is in immediate danger. Upon receiving such a request, the sheriff or police department shall immediately investigate to determine if there is reason to believe that the child's health or safety is in immediate danger and take any necessary action to protect the child.

2. If the investigating officer has reason under s. 48.19 (1) (c) or (d) 5. to take a child into custody, the investigating officer shall take the child into custody and deliver the child to the intake worker under s. 48.20.

3. If the police or other law enforcement officials determine that criminal action is necessary, they shall refer the case to the district attorney for criminal prosecution.

(bm) *Notice of report to Indian tribal agent.* In a county which has wholly or partially within its boundaries a federally recognized Indian reservation or a bureau of Indian affairs service area for the Winnebago tribe, if a county department which receives a report under par. (a) pertaining to a child knows that he or she is an Indian child who resides in the county, the county department shall provide notice, which shall consist only of the name and address of the child and the fact that a report has been received about that child, within 24 hours to one of the following:

1. If the county department knows with which tribe or band the child is affiliated and it is a Wisconsin tribe or band, the tribal agent of that tribe or band.

2. If the county department does not know with which tribe or band the child is affiliated or the child is not affiliated with a Wisconsin tribe or band, the tribal agent serving the reservation or Winnebago service area where the child resides.

3. If neither subd. 1. nor 2. applies, any tribal agent serving a reservation or Winnebago service area in the county.

(c) *Duties of county departments.* 1. Within 24 hours after receiving a report under par. (a), the county department or licensed child welfare agency under contract with the county department shall, in accordance with the authority granted to the county department under s. 48.57 (1) (a), initiate a diligent investigation to determine if the child is in need of protection or services. The investigation shall be conducted in accordance with standards established by the department for conducting child abuse and neglect investigations. If the investigation is of a report of abuse or neglect or threatened abuse or neglect by a caregiver specified in sub. (1) (am) 5. to 8. who continues to have access to the child or a caregiver specified in sub. (1) (am) 1. to 4., or of a report that does not disclose who is suspected of the abuse or neglect and in which the investigation does not disclose who abused or neglected the child, the investigation shall also include observation of or an interview with the child, or both, and, if possible, an interview with the child's parents, guardian or legal custodian. If the investigation is of a report of abuse or neglect or threatened abuse or neglect by a caregiver who continues to reside in the same dwelling as the child, the investigation shall also include, if possible, a visit to that dwelling. At the initial visit to the child's dwelling, the person making the investigation shall identify himself or herself and the county department or licensed child welfare agency involved to the child's parents, guardian or legal custodian. The county department or licensed child welfare agency under contract with the county department may contact, observe or interview the child at any location without permission from the child's parent, guardian or legal custodian if necessary to determine if the child is in need of protection or services, except that the person making the investigation may enter a child's dwelling only with permission from the

child's parent, guardian or legal custodian or after obtaining a court order to do so.

2. a. If the person making the investigation is an employee of the county department and he or she determines that it is consistent with the child's best interest in terms of physical safety and physical health to remove the child from his or her home for immediate protection, he or she shall take the child into custody under s. 48.08 (2) or 48.19 (1) (c) and deliver the child to the intake worker under s. 48.20.

b. If the person making the investigation is an employee of a licensed child welfare agency which is under contract with the county department and he or she determines that any child in the home requires immediate protection, he or she shall notify the county department of the circumstances and together with an employee of the county department shall take the child into custody under s. 48.08 (2) or 48.19 (1) (c) and deliver the child to the intake worker under s. 48.20.

3. If the county department determines that a child, any member of the child's family or the child's guardian or legal custodian is in need of services, the county department shall offer to provide appropriate services or to make arrangements for the provision of services. If the child's parent, guardian or legal custodian refuses to accept the services, the county department may request that a petition be filed under s. 48.13 alleging that the child who is the subject of the report or any other child in the home is in need of protection or services.

4. The county department shall determine, within 60 days after receipt of a report, whether abuse or neglect has occurred or is likely to occur. The determination shall be based on a preponderance of the evidence produced by the investigation. A determination that abuse or neglect has occurred may not be based solely on the fact that the child's parent, guardian or legal custodian in good faith selects and relies on prayer or other religious means for treatment of disease or for remedial care of the child. In making a determination that emotional damage has occurred, the county department shall give due regard to the culture of the subjects and shall establish that the person alleged to be responsible for the emotional damage is unwilling to remedy the harm. This subdivision does not prohibit a court from ordering medical services for the child if the child's health requires it.

5. The county department and licensed child welfare agency under contract with the county department shall maintain a record of its action in connection with each report it receives. The record shall include a description of the services provided to any child welfare agency under contract with the county department shall update the record every 6 months until the case is closed.

6. The county department or licensed child welfare agency under contract with the county department shall, within 60 days after it receives a report from a person required under sub. (2) to report, inform the reporter what action, if any, was taken to protect the health and welfare of the child who is the subject of the report.

7. The county department shall cooperate with law enforcement officials, courts of competent jurisdiction, tribal governments and other human service agencies to prevent, identify and treat child abuse and neglect. The county department shall coordinate the development and provision of services to abused and neglected children and to families where abuse or neglect has occurred or to children and families where circumstances justify a belief that abuse or neglect will occur.

8. Using the format prescribed by the department, each county department shall provide the department with information about each report that it receives or that is received by a licensed child welfare agency that is under contract with the county department and about each investigation it or a licensed child welfare agency under contract with the county department conducts. This information shall be used by the department to monitor services provided by county departments or licensed child welfare agencies under contract with county departments. The department shall use nonidentifying information to maintain statewide statistics on child abuse and neglect, and for planning and policy development.

9. The county agency may petition for child abuse restraining orders and injunctions under s. 48.25 (6).

(cm) *Contract with licensed child welfare agencies.* A county department may contract with a licensed child welfare agency to fulfill its duties specified under par. (c) 1., 2. b., 5., 6. and 8. The confidentiality provisions specified in sub. (7) shall apply to any licensed child welfare agency with which a county department contracts.

(d) *Independent investigation.* 1. In this paragraph, "agent" includes, but is not limited to, a foster parent, treatment foster parent or other person given custody of a child or a human services professional employed by a county department under s. 51.42 or 51.437 who is working with the child under contract with or under the supervision of the county department under s. 46.215 or 46.22.

2. If an agent or employee of a county department of licensed child welfare agency under contract with the county department required to investigate under this subsection is the subject of a report, or if the county department or licensed child welfare agency under contract with the county department determines that, because of the relationship between the county department or licensed child welfare agency under contract with the county department and the subject of a report, there is a substantial probability that the county department or licensed child welfare agency under contract with the county department would not conduct an unbiased investigation, the county department or licensed child welfare agency under contract with the county department shall, after taking any action necessary to protect the child, notify the department. Upon receipt of the notice, the department or a county department or child welfare agency designated by the department shall conduct an independent investigation. If the department designates a county department under s. 46.215, 46.22, 46.23, 51.42 or 51.437, that county department shall conduct the independent investigation. If a licensed child welfare agency agrees to conduct the independent investigation, the department may designate that agency to do so. The powers and duties of the department or designated county department or child welfare agency making an independent investigation are those given to county departments under par. (c).

(4) **IMMUNITY FROM LIABILITY.** Any person or institution participating in good faith in the making of a report, conducting an investigation, ordering or taking of photographs or ordering or performing medical examinations of a child under this section shall have immunity from any liability, civil or criminal, that results by reason of the action. For the purpose of any proceeding, civil or criminal, the good faith of any person reporting under this section shall be presumed. The immunity provided under this subsection does not apply to liability for abusing or neglecting a child.

(5) **CORONER'S REPORT.** Any person or official required to report cases of suspected child abuse or neglect who has reason

able cause to suspect that a child died as a result of child abuse or neglect shall report the fact to the appropriate medical examiner or coroner. The medical examiner or coroner shall accept the report for investigation and shall report the findings to the appropriate district attorney, the department, the county department and, if the institution making the report initially is a hospital, to the hospital.

(6) **PENALTY.** Whoever intentionally violates this section by failure to report as required may be fined not more than \$1,000 or imprisoned not more than 6 months or both.

(7) **CONFIDENTIALITY.** (a) All reports made under this section, notices provided under sub. (3) (bm) and records maintained by the department, county departments or licensed child welfare agencies under contract with the county departments and other persons, officials and institutions shall be confidential. Reports and records may be disclosed only to the following persons:

1. The subject of a report, except that the person or agency maintaining the record or report may not disclose any information that would identify the reporter.

2. Appropriate staff of the department, a county department or licensed child welfare agency under contract with the county departments, or a tribal social services department.

3. An attending physician for purposes of diagnosis and treatment.

3m. A child's parent, guardian, or legal custodian, except that the person or agency maintaining the record or report may not disclose any information that would identify the reporter.

4. A child's foster parent, treatment foster parent or other person having physical custody of the child, except that the person or agency maintaining the record or report may not disclose any information that would identify the reporter.

5. A professional employee of a county department under s. 51.42 or 51.437 who is working with the child under contract with or under the supervision of the county department under s. 46.215 or 46.22.

6. A multidisciplinary child abuse and neglect team recognized by the county department.

6m. A person employed by a child advocacy center recognized by the county board or the county department, to the extent necessary to perform the services for which the center is recognized by the county board or the county department.

7. Another county department, or licensed child welfare agency under contract with that county department, or a tribal social services department that is currently investigating a report of suspected or threatened child abuse or neglect involving a subject of the record or report.

8. A law enforcement officer or agency for purposes of investigation or prosecution.

9. A court or administrative agency for use in a proceeding relating to the licensing or regulation of a facility regulated under this chapter.

10. A court conducting proceedings related to a petition under s. 48.13 or a court conducting dispositional proceedings under subch. VI in which abuse or neglect of the child who is the subject of the report or record is an issue.

10g. A court conducting proceedings related to a petition under s. 48.13 (3m) or (10m) or a court conducting dispositional proceedings under subch. VI in which an issuer is the substantial risk of abuse or neglect of a child who, during the time period covered by the report or record, was in the home of the child who is the subject of the report or record.

10m. A tribal court, or other adjudicative body authorized by a tribe or band to perform child welfare functions, that exercises jurisdiction over children alleged to be in need of protection or services for use in proceedings in which abuse or neglect of a child who is the subject of the report or record is an issue.

10r. A tribal court, or other adjudicative body authorized by a tribe or band to perform child welfare functions, that exercises jurisdiction over children alleged to be in need of protection or services for use in proceedings in which an issue is the substantial risk of abuse or neglect of a child who, during the time period covered by the report or record, was in the home of the child who is the subject of the report or record.

11. The county corporation counsel or district attorney representing the interests of the public and the counsel or guardian ad litem representing the interests of a child in proceedings under subd. 10. or 10g.

11m. An attorney representing the interests of an Indian tribe or band or of an Indian child in proceedings under subd. 10m. or 10r.

12. A person engaged in bona fide research, with the permission of the department. Information identifying subjects and reporters may not be disclosed to the researcher.

13. The department, a county department or licensed child welfare agency ordered to conduct a screening or an investigation of a stepparent under s. 18.88 (2) (c).

14. A grand jury if it determines that access to specified records is necessary for the conduct of its official business.

(am) notwithstanding par. (a) (intro.), a tribal agent who receives notice under sub. (3) (bm) may disclose the notice to a tribal social services department.

(b) Notwithstanding par. (a), either parent of a child may authorize the disclosure of a record for use in a child custody proceeding under s. 767.24 or 767.325 when the child has been the subject of a report. Any information that would identify a reporter shall be deleted before disclosure of a record under this paragraph.

(c) Notwithstanding par. (a), the subject of a report may authorize the disclosure of a record to the subject's attorney. The authorization shall be in writing. Any information that would identify a reporter shall be deleted before disclosure of a record under this paragraph.

(cm) A county agency may disclose information from its records for use in proceedings under s. 48.25 (6), 813.122 or 813.125.

(d) The department may have access to any report or record maintained by a county department or licensed child welfare agency under contract with a county department under this section.

(e) A person to whom a report or record is disclosed under this subsection may not further disclose it, except to the persons and for the purposes specified in this section.

(f) Any person who violates this subsection, or who permits or encourages the unauthorized dissemination or use of information contained in reports and records made under this section, may be fined not more than \$1,000 or imprisoned not more than 6 months or both.

(8) **EDUCATION, TRAINING AND PROGRAM DEVELOPMENT AND COORDINATION.** (a) The department and county departments to the extent feasible shall conduct continuing education and training programs for staff of the department, county departments and tribal social service departments, persons and officials required to report, the general public and others as appropriate. The programs shall be designed to encourage reporting of child abuse and neglect, to encourage self-reporting and voluntary acceptance of services and to improve communication,

cooperation and coordination in the identification, prevention and treatment of child abuse and neglect. The department and county departments shall develop public information programs about child abuse and neglect.

(b) The department shall to the extent feasible ensure that there are available in the state administrative procedures, personnel trained in child abuse and neglect, multidisciplinary programs and operational procedures and capabilities to deal effectively with child abuse and neglect cases. These procedures and capabilities may include, but are not limited to, receipt, investigation, and verification of reports; determination of treatment or ameliorative social services; or referral to the appropriate court.

(c) In meeting its responsibilities under par. (a) or (b), the department or a county department may contract with any public or private organization which meets the standards set by the department. In entering into the contracts the department or county department shall give priority to parental organizations combating child abuse and neglect.

(d) 1. Each county department or licensed child welfare agency under contract with a county department staff member and supervisor whose responsibilities include investigation or treatment of child abuse and neglect protective services approved by the department. The department shall monitor compliance with this subdivision according to rules promulgated by the department.

2. Each year the department shall make available training programs that permit intake workers and county department or licensed child welfare agency under contract with a county department staff members and supervisors to satisfy the requirements under subd. 1. and s. 48.06 (1) (am) 3 and (2) (c).

(9) ANNUAL REPORTS. Annually, the department shall prepare and transmit to the governor, and to the legislature under s. 13.172 (2), a report on the status of child abuse and neglect programs. The report shall include a full statistical analysis of the child abuse and neglect reports made through the last calendar year, an evaluation of services offered under this section and their effectiveness, and recommendations for additional legislative and other action to fulfill the purpose of this section. The department shall provide statistical breakdowns by county, if requested by a county.

(10) CURRENT LIST OF TRIBAL AGENTS. The department shall annually provide to each county department described in sub. (3) (bm) (intro.) a current list of all tribal agents in the state.

**History:** Sup. Ct. Order, 59 W (2d) R1, R3 (1973); 1977 c. 355; 1977 c. 447 s. 210; 1979 c. 300; 1983 a. 172, 190, 299, 538; 1985 a. 29 ss. 917 to 930m, 3200 (56); 1985 a. 176, 234; 1987 a. 27, 186, 209; 1987 a. 332 s. 64; 1987 a. 334, 355, 399, 403; 1989 a. 31, 41, 102, 316, 359; 1991 a. 160, 263; 1993 a. 16, 105, 218, 227, 230, 246, 272, 318, 395, 443, 446, 491.

See note to Art. I, sec. 11, citing *State v. Boggess*, 115 W (2d) 443, 340 NW (2d) 516 (1983).

Section 48.981, 1983 stats., is not unconstitutionally vague. *State v. Hurd*, 135 NW (2d) 266, 400 NW (2d) 42 (Ct. App. 1986).

Duty to report suspected cases of child abuse or neglect under 48.981 (3) (a) prevails over any inconsistent terms in 51.30. 68 Atty. Gen. 342.

Consensual sexual conduct involving sixteen and seventeen year old children does not constitute child abuse. 72 Atty. Gen. 93.

Medical or mental health professional may report suspected child abuse under the permissive provisions of (2) when abuser, rather than victim, is seen in the course of professional duties. 51.30 doesn't bar such reports made in good faith. 76 Atty. Gen. 39.

Contracting out for services under this section is discussed. 76 Atty. Gen. 286.

Disclosure under (7) (a) 1 and (c) is mandatory. 77 Atty. Gen. 84.

Discussion of responsibility of county departments of social services to investigate allegations of child abuse and neglect. Department staff members may interview child on public school property, and may exclude school personnel from the interview. School personnel cannot condition on-site interviews on notification of child's parents. 79 Atty. Gen. 48.

See note to 46.22 citing 79 Atty. Gen. 212.

A district attorney or corporation counsel may reveal the contents of a report made under s.48.981 in the course of a criminal prosecution or one of the civil proceedings enumerated under sub. (7) (a) 10. OAG 10-93.

See note to Art. I, sec. 3, citing *New York v. Ferber*, 458 US 747 (1982).

See note to Art. I, sec. 7, citing *Pennsylvania v. Ritchie*, 480 US 39 (1987).



# Attachment 10

## Domestic Violence Statutes

### 968.075 Domestic abuse incidents; arrest and prosecution. (1) DEFINITIONS. In this section:

(a) “Domestic abuse” means any of the following engaged in by an adult person against his or her spouse or former spouse, against an adult with whom the person resides or formerly resided or against an adult with whom the person has a child in common:

1. Intentional infliction of physical pain, physical injury or illness.
2. Intentional impairment of physical condition.
3. A violation of s. 940.225 (1), (2), or (3).
4. A physical act that may cause the other person reasonably to fear imminent engagement in the conduct described under subd. 1., 2. or 3.

(b) “Law enforcement agency” has the meaning specified in s. 165.83 (1) (b).

(2) CIRCUMSTANCES REQUIRING ARREST. (a) Notwithstanding s.968.07 and except as provided in par. (b), a law enforcement officer shall arrest and take a person into custody if:

1. The officer has reasonable grounds to believe that the person is committing or has committed domestic abuse and that the person’s actions constitute the commission of a crime; and
2. Either or both of the following circumstances are present:
  - a. The officer has a reasonable basis for believing that continued domestic abuse against the alleged victim is likely.
  - b. There is evidence of physical injury to the alleged victim.

(b) If the officer’s reasonable grounds for belief under par. (a) 1. are based on a report of an alleged domestic abuse incident, the officer is required to make an arrest under par. (a) only if the report is received, within 28 days after the day the incident is alleged to have occurred, by the officer or the law enforcement agency that employs the officer.

(3) LAW ENFORCEMENT POLICIES. (a) Each law enforcement agency shall develop, adopt, and implement written policies regarding arrest procedures for domestic abuse incidents. The policies shall include, but are not limited to, the following:

1. Statements emphasizing that:
  - a. In most circumstances, other than those under sub. (2), a law enforcement officer should arrest and take a person into custody if the officer has reasonable grounds to believe that the person is committing or has committed domestic abuse and that the person’s actions constitute the commission of a crime.
  - b. When the officer has reasonable grounds to believe that spouses, former spouses or other persons who reside together or formerly resided together are committing or have committed domestic abuse against each other, the officer does not have to arrest both persons, but should arrest the person whom the officer believes to be the primary physical aggressor. In determining who is the primary physical aggressor, an officer should consider the intent of this section to protect victims of domestic violence, the relative degree of injury or fear inflicted on the persons involved and any history of domestic abuse between these persons, if that history can reasonably be ascertained by the officer.
- c. A law enforcement officer’s decision as to whether or not to arrest under this section may not be based on the consent of the victim to any subsequent prosecution or on the relationship of the persons involved in the incident.

d. A law enforcement officer’s decision not to arrest under this section may not be based solely upon the absence of visible indications of injury or impairment.

2. A procedure for the written report and referral required under sub. (4).

3. A procedure for notifying the alleged victim of the incident of the provisions in sub. (5), the procedure for releasing the arrested person and the likelihood and probable time of the arrested person’s release.

(b) In the development of these policies, each law enforcement agency is encouraged to consult with community organizations and other law enforcement agencies with expertise in the recognition and handling of domestic abuse incidents.

(c) This subsection does not limit the authority of a law enforcement agency to establish policies that require arrests under more circumstances than those set forth in sub. (2).

(4) REPORT REQUIRED WHERE NO ARREST. If a law enforcement officer does not make an arrest under this section when the officer has reasonable grounds to believe that a person is committing or has committed domestic abuse and that person’s acts constitute the commission of a crime, the officer shall prepare a written report stating why the person was not arrested. The report shall be sent to the district attorney’s office, in the county where the acts took place, immediately after investigation of the incident has been completed. The district attorney shall review the report to determine whether the person involved in the incident should be charged with the commission of a crime.

(5) CONTACT PROHIBITION. (a) 1. Unless there is a waiver under par. (c), during the 24 hours immediately following an arrest for a domestic abuse incident, the arrested person shall avoid the residence of the alleged victim of the domestic abuse incident, and, if applicable, any premises temporarily occupied by the alleged victim, and avoid contacting or causing any person, other than law enforcement officers and attorneys for the arrested person and alleged victim, to contact the alleged victim.

2. An arrested person who intentionally violates this paragraph shall be required to forfeit not more than \$1,000.

(b) 1. Unless there is a waiver under par. (c), a law enforcement officer or other person who releases a person arrested for a domestic abuse incident from custody less than 24 hours after the arrest shall inform the arrested person orally and in writing of the requirements under par. (a), the consequences of violating the requirements and provisions of s. 939.621. The arrested person shall sign an acknowledgement on the written notice that he or she has received notice of, and understands the requirements, the consequences of violating the requirements and the provisions of s. 939.621. If the arrested person refuses to sign the notice, he or she may not be released from custody.

2. If there is a waiver under par. (c) and the person is released under subd. 1., the law enforcement officer or other person who releases the arrested person shall inform the arrested person orally and in writing of the waiver and the provisions of s. 939.621.

3. Failure to comply with the notice requirement under subd. 1. regarding a person who is lawfully released from custody bars a prosecution under par. (a), but does not affect the application of s. 939.621 in any criminal prosecution.

(c) At any time during the 24-hour period specified in par. (a), the alleged victim may sign a written waiver of the requirements in par. (a). The law enforcement agency shall have a waiver form available.

(d) The law enforcement agency responsible for the arrest of a person for a domestic abuse incident shall notify the alleged victim of the requirements under par. (a) and the possibility of, procedure for and effect of a waiver under par. (c).

(e) Notwithstanding s. 968.07, a law enforcement officer shall arrest and take a person into custody if the officer has reasonable grounds to believe that the person has violated par. (a).

**(6) CONDITIONAL RELEASE.** A person arrested and taken into custody for a domestic abuse incident is eligible for conditional release. Unless there is a waiver under sub. (5) (c), as part of the conditions of any such release that occurs during the 24 hours immediately following such an arrest, the person shall be required to comply with the requirements under sub. (5) (a) and to sign the acknowledgment under sub. (5) (b). The arrested person's release shall be conditioned upon his or her signed agreement to refrain from any threats or acts of domestic abuse against the alleged victim or other person.

**(6m) OFFICER IMMUNITY.** A law enforcement officer is immune from civil and criminal liability arising out of a decision by the officer to arrest or not arrest an alleged offender, if the decision is made in a good faith effort to comply with this section.

**(7) PROSECUTION POLICIES.** Each district attorney's office shall develop, adopt and implement written policies encouraging the prosecution of domestic abuse offenses. The policies shall include, but not be limited to, the following:

(a) A policy indicating that a prosecutor's decision not to prosecute a domestic abuse incident should not be based:

1. Solely upon the absence of visible indications of injury or impairment;
2. Upon the victim's consent to any subsequent prosecution of the other person involved in the incident; or
3. Upon the relationship of the persons involved in the incident.

(b) A policy indicating that when any domestic abuse incident is reported to the district attorney's office, including a report made under sub. (4), a charging decision by the district attorney should, absent extraordinary circumstances, be made not later than 2 weeks after the district attorney has received notice of the incident.

**(8) EDUCATION AND TRAINING.** Any education and training by the law enforcement agency relating to the handling of domestic abuse complaints shall stress enforcement of criminal laws in domestic abuse incidents and protection of the alleged victim. Law enforcement agencies and community organizations with expertise in the recognition and handling of domestic abuse incidents shall cooperate in all aspects of the training.

**(9) ANNUAL REPORT.** (a) Each district attorney shall submit an annual report to the department of justice listing all of the following:

1. The number of arrests for domestic abuse incidents in his or her county as compiled and furnished by the law enforcement agencies within the county.
2. The number of subsequent prosecutions and convictions of the persons arrested for domestic abuse incidents.

(b) The listing of the number of arrests, prosecutions and convictions under par. (a) shall include categories by statutory reference to the offense involved and include totals for all categories.

**History:** 1987 a. 346; 1989 a. 293; 1993 a. 319.

**NOTE: 1987 Wis. Act 346, which created this section, states the legislative intent and purpose in section 1 of the Act.**

Questions by officer prior to arrest to determine which spouse is primary physical aggressor under sub. (3) (a) 1.b. are investigatory and Miranda warnings are not required where defendant is not deprived of freedom or questioned in coercive environment. *State v. Leprich*, 160 W (2d) 472, 465 NW (2d) 844 (Ct. App. 1991).

Warrantless arrest and detention for bail jumping, 946.49, is authorized if probable cause exists that the arrestee violated the contact prohibition in (5) (a) 1 after being released under ch. 969.78 Atty. Gen. 177.

This section applies to roommates living in university residence halls, whether privately or state owned. If criteria requiring arrest under (2) exist, law enforcement officer must make custodial arrest. 79 Atty. Gen. 109.

# Attachment 11

## Wisconsin Domestic Abuse Programs

<b>County/Reservation</b>	<b>Agency</b>	<b>Business Phone</b>	<b>Crisis Phone</b>
Ashland	New Day Shelter, Northwoods Women	715-682-9566	
Bad River Reservation		715-682-8379	
Brown	Family Violence Center	920-435-0100	920-432-9244
Chippewa	Family Support Center	715-723-1138	1-800-400-7020
Columbia	Hope House	608-745-4722	1-888-584-6790
Dane	Dane County Advocates for Battered Women	608-251-1237	608-251-4445
	WI Coalition Against Domestic Violence	608-255-0539	
Dodge	PAVE	920-887-3810	1-800-775-3785
Door	Help of Door Co.	920-743-8785	1-800-91HELP1
Douglas	Center Against Sexual and Domestic Abuse	715-392-3136	1-800-249-2991
Dunn	The Bridge	715-235-9074	
Eau Claire	Bolton Refuge House	715-834-0628	1-800-252-4357
Fond du Lac	Friends Aware of Violent Relationships	920-923-1700	
Grant	Family Advocates	608-348-5995	1-800-924-2624
Green	Greenhaven	608-325-6489	608-325-7711
Ho Chunk Nation		715-284-9343	
Jefferson	People Against Domestic Abuse	920-674-6748	920-674-6768
Kenosha	Women's Horizons	414-652-1846	414-652-9900
Kewaunee	Violence Intervention Project	920-388-0811	
La Crosse	New Horizons	608-791-2600	
Lac Courte Oreilles Reservation		715-634-8934	
Lac du Flambeau Reservation	Lac du Flambeau Domestic Abuse	715-588-7660	1-800-236-7660
Langlade	AVAIL	715-623-5177	715-623-5767
Lincoln	Haven, Inc.	715-536-9563	715-536-1300
Manitowoc	Manitowoc Co. Domestic Abuse Program	920-684-5770	920-682-0433
Marinette	Rainbow House	715-735-6656	715-735-6656
Milwaukee	Asha Family Services	414-445-2742	414-445-ASHA
	Milwaukee Women's Center	414-272-6199	414-671-6140
	Sojourner Truth House	414-643-1777	414-933-2722
	Task Force on Family Violence	414-643-1911	
Oneida	Tri-County Council on Domestic Violence	715-362-6841	1-800-236-1222
Oneida Reservation		920-869-4415	
Outagamie	Harbor House	920-832-1667	920-832-1666
Ozaukee	Advocates	414-284-3577	
Pierce	Turningpoint	715-425-6751	1-800-338-2882

<b>County/Reservation</b>	<b>Agency</b>	<b>Business Phone</b>	<b>Crisis Phone</b>
Polk	Community Referral Agency	715-825-4414	715-825-4404
Portage	CAP Services, Family Crisis Center	715-345-5208	1-800-472-3377
Potawotomi Reservation		715-478-2903	
Racine	Women's Resource Center	414-633-3274	414-633-3233
Red Cliff Reservation		715-779-3701	
Richland	Passages	608-647-8775	1-800-236-4325
Rock	Janesville YWCA	608-752-5445	
	Salvation Army-SERV	608-364-1083	608-365-1119
Rusk	Time Out Family Abuse Shelter	715-532-6976	1-800-924-0056
Sauk	Hope House	608-356-9123	1-800-584-6790
Shawano	FACES	715-526-3421	
Sheboygan	Safe Harbor	920-452-8611	
Sokaogan Reservation		715-478-7667	
St. Croix Reservation		715-349-2195	
Stockbridge-Munsee Reservation		715-793-4111	
Taylor	Stepping Stones	715-748-3795	715-748-5140
Vernon	Vernon Co. Domestic Abuse Program	608-637-7052	
Walworth	Assoc. for the Prevention of Family Violence	414-723-4653	
Washington	Friends of Abused Families	414-334-5598	
Winnebago	Regional Domestic Abuse Services	920-729-5727	920-235-5998
Wood	Family Center	715-421-1511	
	Personal Development Center	715-384-2971	715-384-5555

**National Domestic Violence Hotline ..... 1-800-799-SAFE**

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